

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14884

1. PLACE OF DEATH a. COUNTY <b>Towson</b> <b>Balto.</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> c. LENGTH OF STAY IN TB <b>45yrs.</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
3. NAME OF DECEASED (Type or print) First <b>Ida</b> Middle <b>C.</b> Last <b>Aler</b>		4. DATE OF DEATH Month <b>11</b> Day <b>4</b> Year <b>1967</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6/29/1910</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>	9. AGE (In years last birthday) yrs. <b>57</b>
11. BIRTHPLACE (County & State, or foreign country) <b>Derbyshire, England</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Charles Crump</b>		14. MOTHER'S MAIDEN NAME <b>Amy Clark</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT <b>Family records</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED: (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>11/2</b> , <b>1967</b> , to <b>11/4</b> , <b>1967</b> , that (I) (we) last saw the deceased alive on <b>11/4</b> , <b>1967</b> , and that death occurred at <b>6:10pM</b> , from causes and on the date stated above.			
22a. SIGNATURE <i>[Signature]</i>		22b. DATE SIGNED <b>11-4-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. Jamora</b>		22d. ADDRESS <b>M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/></b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>Nov. 7, 1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Maryland</b>
24. FUNERAL DIRECTOR <b>John Burke Sons, Towson, Md.</b>		25a. RECEIVED BY REGISTRAR <b>NOV 7 1967</b>	
		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14885

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>H.A.</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. LENGTH OF STAY IN TB	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		d. STREET ADDRESS <u>XXX 803 Bentwillon Dr.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Forest Haven Nursing Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Angie C. Anderson</u>		4. DATE OF DEATH Month Day Year <u>Nov. 29 19 67</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>Wh</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 18/81</u>
9. AGE (In years last birthday) <u>86</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Cornelius Chappell</u>		14. MOTHER'S MAIDEN NAME <u>Josephine Webster</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Doris E. Przylepa</u> <u>803 Bentwillow Dr. - Glenburnie, Md.</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>BARBARIC SELF-MURDER - CHOKED</u> DUE TO <u>DISEASE</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>PULMONARY EDEMA</u> (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>7/1</u> , 19 <u>67</u> , to <u>11/29</u> , 19 <u>67</u> , that (I) (we) lost saw the deceased alive on <u>11/29</u> , 19 <u>67</u> , and that death occurred at <u>4 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>John Shaw</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>John Shaw</u>		22d. ADDRESS <u>5800 Edmondson Ave.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>12/2/67 - Burial</u>		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY <u>Woodbine Cem.</u>		23d. LOCATION (City or Town) (County) (State) <u>Harrisonburg, Va.</u>	
24. FUNERAL DIRECTOR <u>Witzke F. D. - 4101 Edmondson Ave.</u>		25a. REC'D BY REGISTRAR <u>DA DEC 1 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles J. J...</u>	

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14878

CERTIFICATE OF DEATH

14886

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>TOWSON</b> c. LENGTH OF STAY IN 1b <b>03.1</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>ST. JOSEPH HOSPITAL</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTO</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b> d. STREET ADDRESS <b>520 S. 48th STREET #21224</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>MARY E. ANDRION</b>		4. DATE OF DEATH Month Day Year <b>NOVEMBER 29 19 67</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>SEPTEMBER 20, 1881</b>
9. AGE (In years last birthday) <b>86 YRS.</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOMEMAKER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>AT HOME</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>ITALY</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>? ASCHIERE</b>		14. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT <b>Elgie J. Andrion : 520 S. 48th St. # 24</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>MYOCARDIAL INFARCTION</b> <b>4201</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>NOVEMBER 28, 19 67</b> , to <b>NOVEMBER 29 67</b> , that (I) (we) last saw the deceased alive on <b>NOVEMBER 29 19 67</b> , and that death occurred at <b>8:20AM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>Ramon P. Lopez</b>		22b. DATE SIGNED <b>NOVEMBER 29, 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>RAMON P. LOPEZ, M.D.</b>		22d. ADDRESS <b>7620 YORK ROAD TOWSON, MD. #21204</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12-2-67.</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Sacred Heart Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>7401 Berman Hill Rd., Md.</b>	
24. FUNERAL DIRECTOR <b>Charles S. Zuler</b>		25a. REC'D BY REGISTRAR <b>DEC 4 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

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CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
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1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Summit Nursing Home</u>		d. STREET ADDRESS <u>211 Oak Forest Place</u>	
3. NAME OF DECEASED (Type or print) <u>Atkinson, Emily</u> First Middle Last		4. DATE OF DEATH Month <u>11</u> Day <u>8</u> Year <u>1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-3-01</u>
9. AGE (In years last birthday) yrs. <u>66</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Sec</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Cling</u>		14. MOTHER'S MAIDEN NAME <u>Caroline</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>212-03-1849A</u>	
17. INFORMANT <u>Roger Atkinson, Jr.</u>		Address <u>211 Oak Forest Place</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of the cervix with</u> DUE TO <u>undescribed metastases</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on <u>11/7</u> 19 <u>67</u> and that death occurred at <u>1:05 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>E. Kasaitis, M.D.</u>		22b. DATE SIGNED <u>11/8/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>E. KASAITIS, M.D.</u>		22d. ADDRESS <u>1801 FREDERICK RD #21228</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	23b. DATE THEREOF <u>11/11/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Prospect Hill Cem.</u>	23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Md.</u>
24. FUNERAL DIRECTOR <u>Witzke F. D. - 4101 Edmondson Ave.</u>		25a. REC'D BY REGISTRAR DATE <u>NOV 10 1967</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

Page 1

OFFICE OF THE SECRETARY

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# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14881

## CERTIFICATE OF DEATH

14888

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>_____</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>St. Joseph Hospital, Towson, Md. 21204</b>		d. STREET ADDRESS <b>3012 Harview Avenue</b>	
3. NAME OF DECEASED (Type or print) First <b>TROY</b> Middle <b>E.</b> Last <b>AUVIL</b>		4. DATE OF DEATH Month <b>November</b> Day <b>25</b> Year <b>19 67</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1-3-1882</b>
9. AGE (In years last birthday) yrs. <b>85</b>		10. IF UNDER 1 YEAR Months <b>_____</b> Days <b>_____</b> Hours <b>_____</b> Min. <b>_____</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>West Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Sansen Auvil</b>		14. MOTHER'S MAIDEN NAME <b>Columbia VanMeter</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>413-12-7943</b>	
17. INFORMANT <b>Mary C. Bayne-3012 Harview Ave.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <b>4500</b> IMMEDIATE CAUSE (a) <b>Generalized arteriosclerosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>_____</b> (c) <b>_____</b>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Contusion, occipital region, left orbital region</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b>_____</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>11-19</b> , 19 <b>67</b> , to <b>11-25</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>11-25-</b> 19 <b>67</b> , and that death occurred at <b>2:00 PM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>Arturo A. Pidlaon MD</b>		22b. DATE SIGNED <b>11-25-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Arturo A. Pidlaon</b>		22d. ADDRESS <b>7620 York Road, Towson, Md. 21204</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>11/29/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Shiloh Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Barbour Co.-W. Va.</b>
24. FUNERAL DIRECTOR <b>Robert C. Altenburg Funeral Home, Inc.</b>		25a. REC'D BY REGISTRAR <b>NOV 29 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Released by Medical Examiner's Office - by Dr. France 11-25-67

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14882

16429

1 PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>DORCHESTER</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>		c. LENGTH OF STAY IN TB <b>105 DAYS</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CAMBRIDGE</b>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>VETERANS ADMINISTRATION HOSPITAL</b>		d. STREET ADDRESS <b>412 CAMPBELL STREET</b>	
3 NAME OF DECEASED (Type or print) First <b>JOE</b> Middle <b>L.</b> Last <b>BAILEY</b>		4 DATE OF DEATH Month <b>NOVEMBER</b> Day <b>30</b> Year <b>19 67</b>	
5 SEX <b>MALE</b>	6 COLOR OR RACE <b>NEGRO</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>OCTOBER 1, 1920</b>
9. AGE (In years last birthday) yrs <b>47</b>		IF UNDER 1 YEAR Months <b>4</b> Days <b>7</b> Hours <b>15</b> Min <b>00</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LABORER</b>		10b. KIND OF BUSINESS OR INDUSTRY	11 BIRTHPLACE (County & State, or foreign country) <b>NEWSOME, VIRGINIA</b>
12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13 FATHER'S NAME <b>LOVE MOSES</b>	
14 MOTHER'S MAIDEN NAME <b>ETHEL HILL</b>		15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>YES WW II</b>	
16 SOCIAL SECURITY NO <b>245 20 60 86</b>		17 INFORMANT <b>CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>PULMONARY EDEMA</b> DUE TO (b) <b>CHRONIC COR PULMONALE</b> DUE TO (c) <b>PULMONARY FIBROSIS AND EMPHYSEMA</b>			INTERVAL BETWEEN ONSET AND DEATH <b>RECENT</b>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART (a)			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f (City or town) (County) (State)
21. I certify that (this hospital) attended the deceased from <b>8/17/67</b> , 19__ to <b>11/30/67</b> , 19__, that (we) last saw the deceased alive on <b>11/30/67</b> , 19__, and that death occurred at <b>3:45AM</b> , from causes and on the date stated above.			
22a SIGNATURE <i>Jorge A. Fabara</i>		22b DATE SIGNED <b>11/30/67</b>	
22c PHYSICIAN'S NAME (Type) <b>JORGE A. FABARA, M. D.</b>		22d ADDRESS <b>VAH FORT HOWARD, MARYLAND</b>	
23a BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b DATE THEREOF <b>1/4/67</b>	23c NAME OF CEMETERY OR CREMATORY <b>Bethel Cemetery</b>	23d LOCATION (City or Town) (County) (State) <b>Cambridge, Maryland</b>
24. FUNERAL DIRECTOR <i>St Clair Funeral Home</i>		25a REC'D BY REGISTRAR <b>DEC 8 1967</b>	25b REGISTRAR'S SIGNATURE <i>Charles J. [Signature]</i>





TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME 51  
6M 1/67

FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14883

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14889

1 PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Essex (21)</b>		c. LENGTH OF STAY IN 1b <b>Essex (21)</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>191 "A" Maple Road</b>		d. STREET ADDRESS <b>191 "A" Maple Rd.</b>	
3 NAME OF DECEASED (Type or print) <b>LOUIS G. BALDI</b>		4 DATE OF DEATH Month <b>November</b> 2 Day <b>19</b> Year <b>67</b>	
5 SEX <b>Male</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>Oct. 1, 1907</b>
9 AGE (In years last birthday) <b>60 yrs</b>		IF UNDER 1 YEAR Months Days Hours Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Steel worker</b>		10b KIND OF BUSINESS OR INDUSTRY <b>Bethlm Steel</b>	
11 BIRTHPLACE (State or foreign country) <b>Italy</b>		12 CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13 FATHER'S NAME <b>Frank Baldi</b>		14 MOTHER'S MAIDEN NAME <b>Margaret Holready</b>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes WWII</b>		16 SOCIAL SECURITY NO <b>213 09 0074</b>	
17 INFORMANT <b>Louis D. Baldi</b>		Address <b>Same</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY <b>4201 Acute occlusion in Coronary</b> IMMEDIATE CAUSE (a) <b>Acute occlusion in Coronary</b> DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 8)	
20c TIME OF INJURY Month, Day, Year hour a.m. p.m. <b>19</b>		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Theo C. Patterson</b>		22. DATE SIGNED <b>11/7/67</b>	
EXAMINER'S NAME (Type) <b>THEO C. PATTERSON</b>		105 Main St., Dundalk, Md.	
23a BURIAL, CREMATION, or other disposition <b>Burial</b>		23b DATE THEREOF <b>11/10/67</b>	
23c NAME OF CEMETERY OR CREMATORY <b>Balto. National Cemetery</b>		23d LOCATION (City or town) (County) (State) <b>Baltimore, Md.</b>	
24 FUNERAL DIRECTOR <b>Brudzinski Funeral Home</b>		407 Eastern Ave.	
25a REC'D BY REGISTRAR DATE <b>NOV 9 1967</b>		25b REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

100



## CERTIFICATE OF DEATH

12884

1 PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Maryland</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore County</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Spring Grove State Hospital</u>		d. STREET ADDRESS <u>1001 West Joppa Road</u>	
3 NAME OF DECEASED (Type or print) <u>Sister Sophia</u>		4 DATE OF DEATH Month <u>November</u> Day <u>20</u> Year <u>1967</u>	
5 SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>11/28/07</u>
9 AGE (In years lost birthday) <u>60</u> yrs.		10 IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Nun</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Convent</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Maryland</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Waladislau Bankoski</u>		14. MOTHER'S MAIDEN NAME <u>Elenora Yaroch</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>  </u>	
17. INFORMANT <u>Records: Spring Grove State Hospital</u>		Address <u>  </u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Arrest</u> DUE TO (b) <u>Progressive Bulbar Palsy</u> DUE TO (c) <u>Amphotrophic Lateral Sclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u> <u>5 years</u> <u>5 years</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>  </u>		19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>  </u>	
20c TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>	20f (City or town) (County) (State) <u>  </u>
21. I certify that <u>X</u> (this hospital) attended the deceased from <u>August 17</u> , 19 <u>67</u> , to <u>November 20</u> 19 <u>67</u> , that <u>X</u> (we) last saw the deceased alive on <u>November 20</u> 19 <u>67</u> , and that death occurred at <u>8:10aM</u> , from causes and on the date stated above			
22a SIGNATURE <u>Anthony C. Young, M.D.</u>		22b DATE SIGNED <u>20 Nov 67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Anthony C. Young, M.D.</u>		22d. ADDRESS <u>SPRING GROVE STATE HOSPITAL</u> <u>Baltimore, Maryland 21228</u>	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Nov. 24, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Convent Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>1001 Joppa Rd. Towson Md.</u>
24. FUNERAL DIRECTOR <u>B. Lemon Lemmon</u>		25a. REC'D BY REGISTRAR <u>NOV 22 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>B. Lemon Lemmon</u>		25c. REGISTRAR'S SIGNATURE <u>John A. Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14885

## CERTIFICATE OF DEATH

14881

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (Pages 1 and 2) should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution or Residence before admission) a. STATE <b>Maryland</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>1 mth 2dys</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>SPRING GROVE STATE HOSPITAL</b>		d. STREET ADDRESS <b>4140 Mountwood Road</b>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3 NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>E.</b> Last <b>Barnes</b>		4 DATE OF DEATH Month <b>November</b> Day <b>6</b> Year <b>19 67</b>	
5 SEX <b>female</b>	6 COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 30, 1888</b>
9 AGE (In years last birthday) <b>79</b> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>	11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>
12 CITIZEN OF WHAT COUNTRY? <b>U. S.</b>		13. FATHER'S NAME <b>George Dixon</b>	
14. MOTHER'S MAIDEN NAME <b>Hannah Emich</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	
16. SOCIAL SECURITY NO <b>213-18-6961</b>		17. INFORMANT <b>Raymond O. Hulse - 4140 Mountwood Rd. Records: SPRING GROVE STATE HOSPITAL</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Pneumonia, bilateral, with abscess formation.</b> DUE TO <b>Organism undetermined at this time</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) _____ (c) _____			INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b>
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arteriosclerotic cardiovascular heart disease secondary to arteriosclerosis, generalized</b>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <del>he</del> (this hospital) attended the deceased from <b>Oct. 2, 1967</b> to <b>Nov. 6, 1967</b> , that <del>he</del> (we) last saw the deceased alive on <b>Nov. 6, 1967</b> , and that death occurred at <b>8:35</b> M, from causes and on the date stated above.			
22a. SIGNATURE <i>Anthony J. Young, M.D.</i>		ATTENDING PHYSICIAN <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>	22b. DATE SIGNED <b>11-7-67</b>
22c. PHYSICIAN'S NAME (Type) <b>Anthony J. Young, M.D.</b>		22d. ADDRESS <b>SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>11/10/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Western Cem.</b>	23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Md.</b>
24. FUNERAL DIRECTOR <b>Witzke F. D. - 4101 Edmondson Ave.</b>		25a. REC'D BY REGISTRAR DATE <b>NOV 8 1967</b>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

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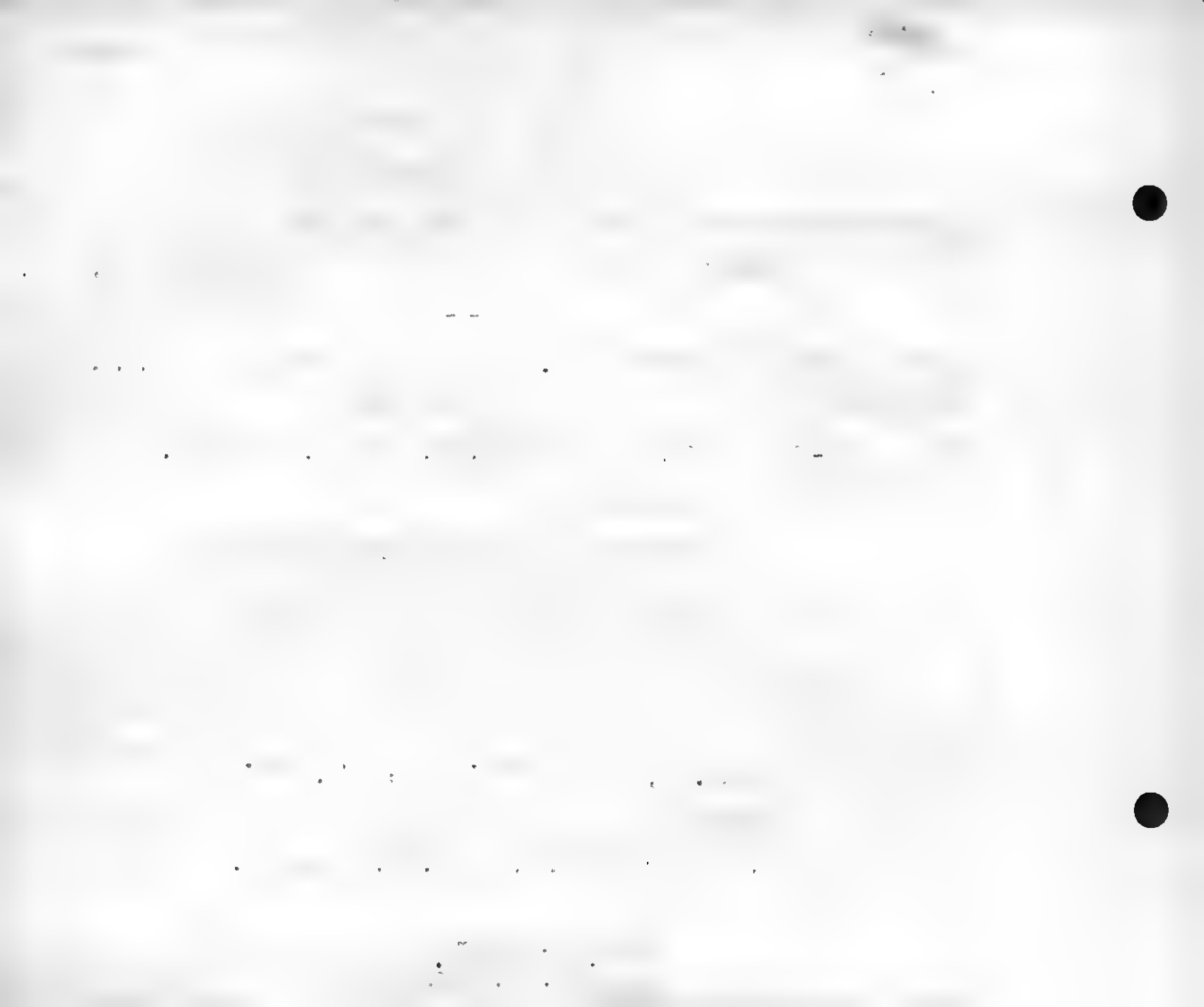


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1 PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND						2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>				c. LENGTH OF STAY IN 1b <b>27 DAYS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>VETERANS ADMINISTRATION HOSPITAL</b>						d. STREET ADDRESS <b>3013 FAIT AVENUE</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First <b>NORMAN</b> Middle <b>JOHN</b> Last <b>BAUER</b>						4. DATE OF DEATH Month <b>NOVEMBER</b> Day <b>15</b> Year <b>1967</b>					
5 SEX <b>MALE</b>		6 COLOR OR RACE <b>WHITE</b>		7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1-1-11</b>		9. AGE (in years last birthday) yrs <b>56</b>		10. UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>MATERIAL HANDLER</b>				10b KIND OF BUSINESS OR INDUSTRY <b>ELECTRICAL CO.</b>		11. BIRTHPLACE (County & State or foreign country) <b>BALTIMORE, MARYLAND</b>				12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13 FATHER'S NAME <b>JOHN BAUER</b>						14 MOTHER'S MAIDEN NAME <b>ANNA HENRY</b>					
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>YES WW-II</b>				16 SOCIAL SECURITY NO <b>217 01 99 05</b>		17. INFORMANT Address <b>CLIN.REC., VAH, FT. HOWARD, MD.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>PULMONARY EDEMA</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>UNRESECTABLE ANAPLASTIC CARCINOMA RIGHT LUNG</b> DUE TO (c)											
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)							
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)			
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>Oct. 19 1967</b> to <b>Nov. 15 1967</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>Nov. 15, 1967</b> , and that death occurred at <b>4:55 P.M.</b> from causes and on the date stated above.											
22a. SIGNATURE <i>George C. McElpatrick</i> M.D.						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b DATE SIGNED <b>11 16 67</b>			
22c. PHYSICIAN'S NAME (Type) <b>GEORGE C. MC ELPATRICK, M. D.</b>						22d ADDRESS <b>VAH, FT. HOWARD, MD.</b>					
23a BURIAL, CREMATION REMOVAL (Specify) <b>BURIAL</b>			23b DATE THEREOF <b>11/20/67</b>		23c NAME OF CEMETERY OR CREMATORY <b>Sacred Heart Cemetery</b>			23d LOCATION (City or Town) (County) (State) <b>Balto. Co. Md.</b>			
24. FUNERAL DIRECTOR <b>Charles S. Zeiler</b>						25a REC'D BY REGISTRAR DATE <b>NOV 20 1967</b>		25b REGISTRAR'S SIGNATURE <i>Charles Judge</i>			



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14693

13887

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institut on Residence before adm ssion) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>		c. LENGTH OF STAY IN it <u>40 yrs.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Greater Baltimore Medical Center</u>		d. STREET ADDRESS <u>Boy 112 Dulaney Valley Rd. 21057</u>	
3. NAME OF DECEASED (Type or print) <u>LOUISE</u> First Middle Last <u>BELLE</u>		4. DATE OF DEATH Month <u>11</u> Day <u>18</u> Year <u>1967</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>Cau.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-30-95</u>
9. AGE (in years) <u>72</u> yrs		10. IF UNDER 1 YEAR Months <u>11</u> Days <u>18</u> Hours <u>19</u> Min <u>67</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>salesman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Office MacLennan</u>	
11. BIRTHPLACE (County, State or foreign country) <u>Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Louis Belle</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of serv ce)		16. SOCIAL SECURITY NO <u>212-093642</u>	
17. INFORMANT <u>Anna Belle</u>		Address <u>Boy 112 Dulaney Valley Rd. 21057</u>	
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Cardiac failure</u> DUE TO (b) <u>Coronary Artery Disease</u> DUE TO (c) <u>15 years</u>			INTERVAL BETWEEN ONSET AND DEATH <u>15 years</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>1952</u> , 19 <u>52</u> , to <u>11/19/1967</u> ; that (I) (we) last saw the deceased alive on <u>11/13/67</u> , and that death occurred at <u>3:35 PM</u> from causes and on the date stated above			
22a. SIGNATURE <u>John R. Davis</u>		22b. DATE SIGNED <u>11/19/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>JOHN R. DAVIS</u>		22d. ADDRESS <u>6629 Charles Way</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>11-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Landon Park</u>	23d. LOCATION (City or town) (County) (State) <u>Ed. Md.</u>
24. FUNERAL DIRECTOR <u>Long Byers 8728 Liberty Road</u>		25a. REGISTERED REGISTRAR <u>NOV 21 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Long</u>		DATE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



14888

# CERTIFICATE OF DEATH

Y4352

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2, and direct, page 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

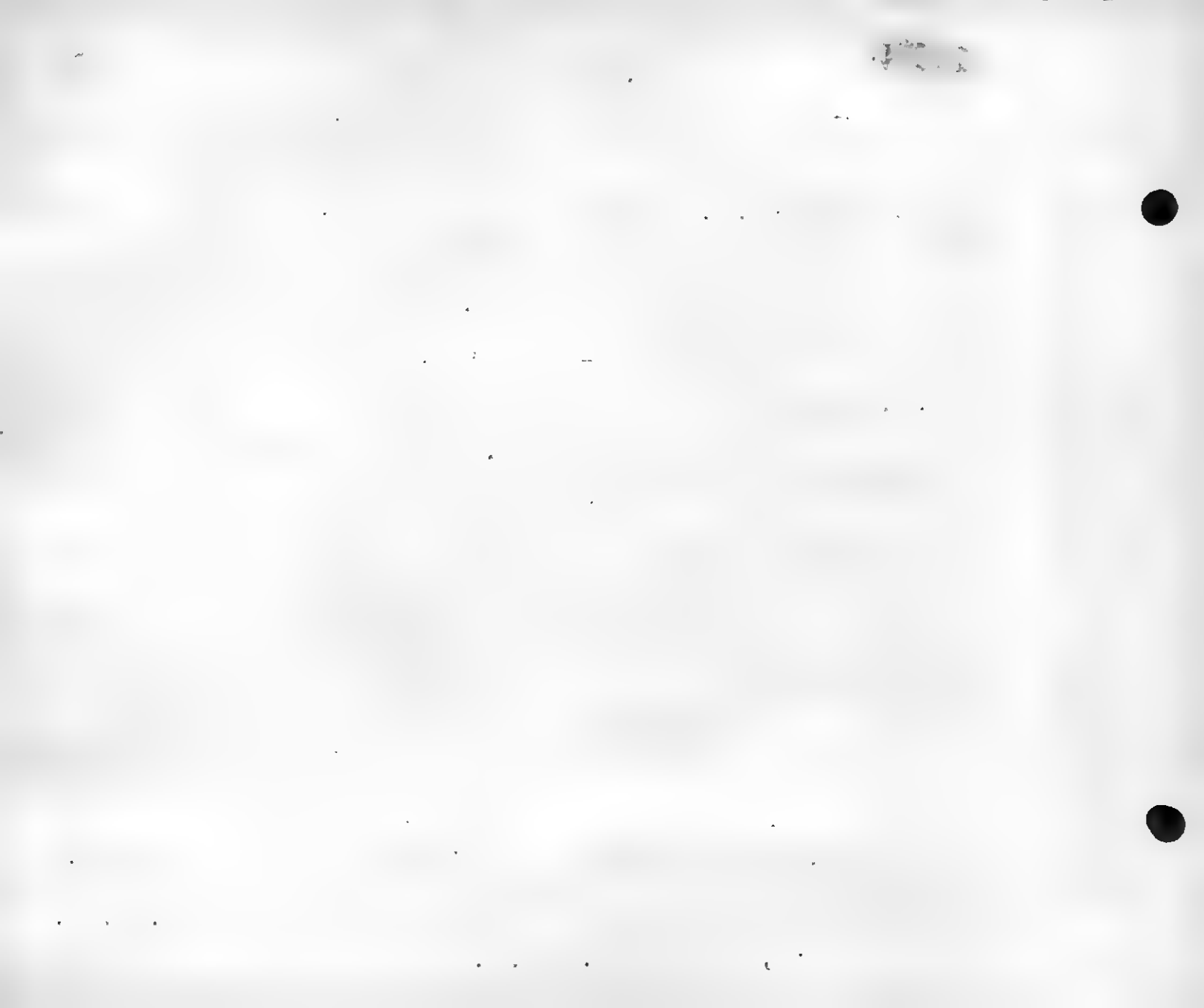
100.5

1988

14855

By:





14890

CERTIFICATE OF DEATH

14896

1 PLACE OF DEATH a. COUNTY <b>Baltimore</b>		2 USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mount Wilson</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Barton</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Mount Wilson State Hospital</b>		d. STREET ADDRESS <b>CL-7</b>	
3 NAME OF DECEASED (Type or print) <b>CLIFTON</b>		4 DATE OF DEATH Month <b>Nov.</b> Day <b>24</b> Year <b>1967</b>	
5 SEX <b>Male</b>	6 COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>Dec. 12, 1897</b>
9 AGE (In years last birthday) <b>69</b> yrs		10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Labor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Paper Mill</b>	
11 BIRTHPLACE (County & State, or foreign country) <b>USA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>JOHN BOAL</b>		14. MOTHER'S MAIDEN NAME <b>KATHERINE SHAW</b>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes give war or dates of service)		16 SOCIAL SECURITY NO <b>215 10 8047</b>	
17 INFORMANT <b>Records, Mt. Wilson State Hospital</b>		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY <b>ABDOMINAL CARCINOMATOSIS</b> IMMEDIATE CAUSE (a) <b>CARCINOMA of PANCREAS</b> DUE TO (b) <b>CARCINOMA of PANCREAS</b> DUE TO (c) <b>CARCINOMA of PANCREAS</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>PULMONARY EMPHYSEMA; moderately advanced pulmonary tuberculosis</b>			
19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from causes and on the date stated above			
22a SIGNATURE <b>W. Newcomer</b>		22b DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>Wm. Newcomer, M.D., Superintendent</b>		22d. ADDRESS <b>Mount Wilson, Maryland</b>	
23a BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b DATE THEREOF <b>Nov. 27, 1967</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>LAUREL HILL</b>		23d. LOCATION (City or town) (County) (State) <b>MCCOOW MILLS MARYLAND</b>	
24 FUNERAL DIRECTOR <b>Charles Judge</b>		25a REC'D BY REGISTRAR DATE <b>NOV 28 1967</b>	
25b REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13891

CERTIFICATE OF DEATH

14157

1 PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) a. STATE <u>MARYLAND</u> - <u>BA</u> b. COUNTY <u>BA</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>		c. LENGTH OF STAY IN IB <u>APRIL-1966</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>SHANGRI - LA NURSING HOME</u>		d. STREET ADDRESS <u>3812 Woodbine Ave</u> e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <u>MAGPALENEHOLL BOETTINGER</u>		4 DATE OF DEATH Month <u>11</u> Day <u>28</u> Year <u>1967</u>	
5 SEX <u>Female</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-17-1900</u> 9 AGE (In years lost birthday) <u>67</u> yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Secretary</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>BALTIMORE</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13 FATHER'S NAME <u>Michael J. Kell</u>		14. MOTHER'S MAIDEN NAME <u>Wettig</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>218-22-0173</u>	
17. INFORMANT <u>Wm. G. Boettinger</u> Address <u>3812 Woodbine Ave</u>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY 305X IMMEDIATE CAUSE (a) <u>Aspirational Bronchopneumonia</u> DUE TO (b) <u>Presenile Dementia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour o.m. <u>19</u> p.m.	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>4-11-1966</u> , to <u>11-28-1967</u> , that (I) (we) last saw the deceased alive on <u>11-28-1967</u> , and that death occurred at <u>10:52 M.</u> , from causes and on the date stated above			
22a. SIGNATURE <u>Cesar Valle Caverio</u> M.D.		22b. DATE SIGNED <u>11-28-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>CESAR VALLE CAVERO</u>		22d. ADDRESS <u>8624 Liberty Rd. Baltimore Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>11-30-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>BALTIMORE, MD</u>
24. FUNERAL DIRECTOR <u>Elsworth Armaest</u> ADDRESS <u>4600 Liberty Heights Ave</u>		25a REC'D BY REGISTRAR DATE <u>NOV 29 1967</u> 25b REGISTRAR'S SIGNATURE	



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VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
14892									
CERTIFICATE OF DEATH									
14898									
1. PLACE OF DEATH a. COUNTY <b>BALTO</b> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>BALTO</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ESSEX</b>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ESSEX</b> <b>03</b>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>302 LORRAINE</b>					d. STREET ADDRESS <b>302 LORRAINE</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>ALEXANDER S. BORSOS</b>					4. DATE OF DEATH <b>NOV. 21 1967</b>				
5. SEX <b>M</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>SEPT. 14 1905</b>		9. AGE (In years last birthday) <b>62 yrs</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <b>DETH. STEEL</b>		11. BIRTHPLACE (County & State or foreign country) <b>PA.</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>DANIEL BORSOS</b>					14. MOTHER'S MAIDEN NAME <b>?</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>UNKNOWN</b>			16. SOCIAL SECURITY NO. <b>213-07-3145</b>		17. INFORMANT <b>VIRGINIA BORSOS</b>			Address <b>ABOVE</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>GENERALIZED METASTATIC</b> <b>1772</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) <b>CARCINOMA, PRIMARY SITE</b> (c) <b>UNDETERMINED</b>									INTERVAL BETWEEN ONSET AND DEATH <b>1 YR</b>
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>MAR 30</b> , 1952 to <b>NOV 21</b> , 1967, that (I) (we) last saw the deceased alive on <b>NOV 21</b> , 1967, and that death occurred at <b>6:25 PM</b> , from causes and on the date stated above.									
22a. SIGNATURE <b>Joseph Micali</b> M.D.					ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>11/22/67</b>		
22c. PHYSICIAN'S NAME (Type) <b>JOSEPH MICALI, M.D.</b>					22d. ADDRESS <b>108 S. TAYLOR AVE ESSEX, MD. 21221</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>11/24/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>GARDENS OF FAITH</b>			23d. LOCATION (City or town) (County) (State) <b>BALTO. MD.</b>		
24. FUNERAL DIRECTOR <b>J.G. CONNELLY SONS</b>					25a. REC'D BY REGISTRAR <b>300 MACE</b>		25b. REGISTRAR'S SIGNATURE <b>NOV 27 1967</b>		

100





14893

CERTIFICATE OF DEATH

14899

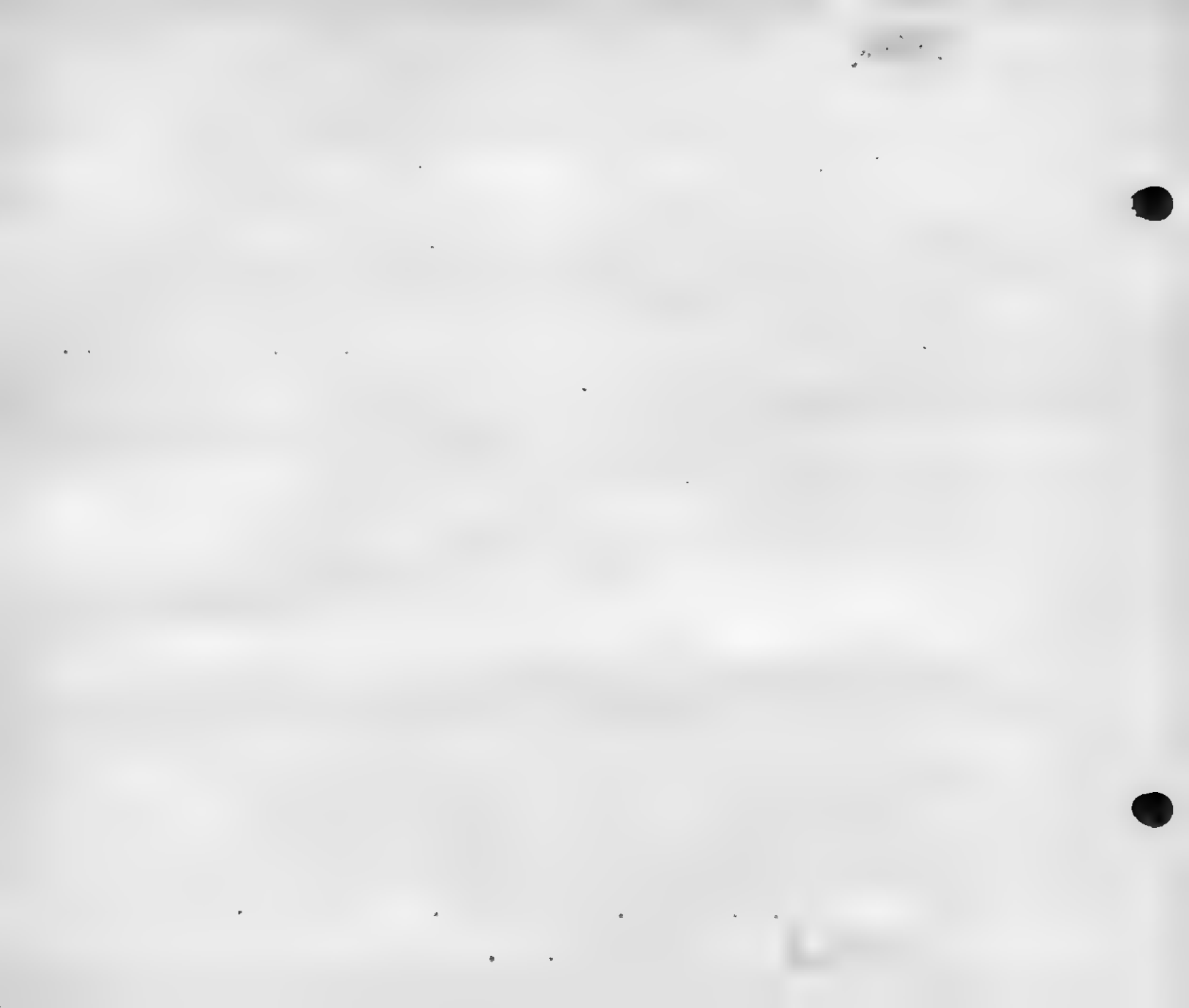
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1 PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>1-1</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>		c. LENGTH OF STAY IN 1b <b>3 days</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Veterans Administration Hospital</b>		d. STREET ADDRESS <b>8025 Bank Street</b>	
3 NAME OF DECEASED (Type or print) First <b>GEORGE</b> Middle <b>BOTTLEMAC</b> Last <b>E</b>		4 DATE OF DEATH Month <b>NOVEMBER</b> Day <b>10</b> Year <b>19 67</b>	
5 SEX <b>Male</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10/13/96</b>
9 AGE (In years last birthday) <b>71</b>		IF UNDER 1 YEAR Months <b>71</b> Days <b>10</b> Hours <b>10</b> Min <b>57</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Chauffeur</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>City</b>	11 BIRTHPLACE (County & State or foreign country) <b>Baltimore, Maryland</b>
12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Henry Bottlemace</b>	
14. MOTHER'S MAIDEN NAME <b>Margaret Holty</b>		15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes WW I</b>	
16 SOCIAL SECURITY NO <b>218-07-77-81</b>		17. INFORMANT Address <b>Clinical Records, VAH, Fort Howard, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>CANCER OF LARYNX</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>CHRONIC BRONCHITIS</b> (c) <b>ARTERIOSCLEROTIC HEART DISEASE</b>			INTERVAL BETWEEN ONSET AND DEATH <b>months</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour <b>19</b> a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>November 7, 19 67</b> to <b>November 10, 19 67</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>November 10, 19 67</b> , and that death occurred on <b>12:25 AM</b> from causes and on the date stated above			
22a. SIGNATURE <b>GRACITO V. PATRICIO, M.D.</b>			22b. DATE SIGNED <b>11/10/67</b>
22c. PHYSICIAN'S NAME (Type) <b>Gracito V. Patricio</b>			22d. ADDRESS <b>VA HOSPITAL, FORT HOWARD, MARYLAND</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>11/13/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>	23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Maryland</b>
24 FUNERAL DIRECTOR <b>ZANNINO FUNERAL HOME</b>		25a. REC'D BY REGISTRAR <b>236 S. Conkling St. NOV 13 1967</b> DATE 25b. REGISTRAR'S SIGNATURE	



1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon "pages 1 and 2" should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
14894 CERTIFICATE OF DEATH 14860											
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Owings Mills</u>						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lanham</u>					
c. LENGTH OF STAY IN 1b <u>5 yrs.</u>						d. STREET ADDRESS <u>9313 Wyatt Drive</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Rosewood State Hospital</u>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Middle Last <u>Ann Marie BOWLES</u>						4. DATE OF DEATH Month Day Year <u>11 17 19 67</u>					
5. SEX <u>Female</u>						6. COLOR OR RACE <u>White</u>					
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>						8. DATE OF BIRTH <u>4/14/59</u>					
9. AGE (In years last birthday) <u>8</u> yrs.						10. IF UNDER 1 YEAR Months Days					
11. IF UNDER 24 HRS. Hours Min.						12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Dependent</u>						10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>					
11. BIRTHPLACE (County & State, or foreign country) <u>Washington, D. C.</u>						12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>					
13. FATHER'S NAME <u>Morris Bowles</u>						14. MOTHER'S MAIDEN NAME <u>Audrey Politella</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>						16. SOCIAL SECURITY NO. <u>--</u>					
17. INFORMANT <u>Rosewood Records, Owings Mills, Maryland</u>						18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Pneumonia</u> Conditions, if any, which gave rise to immediate cause (b) <u>congenital cerebral defect</u> (c), stating the underlying cause last, <u>due to unknown etiology.</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>						20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work					
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)						20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <u>5-28/62</u> , 19... to <u>11-17/67</u> , 19..., that (s) (we) last saw the deceased alive on <u>11-17</u> , 19 <u>67</u> , and that death occurred at <u>8:45 AM</u> from the causes and on the date stated above											
22a. SIGNATURE <u>Soo Hwa Lee</u> M.D.						22b. DATE SIGNED <u>11/17/67</u>					
22c. PHYSICIAN'S NAME (Type) <u>Soo Hwa Lee</u>						22d. ADDRESS <u>Rosewood State Hosp Owings Mills Md</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>						23b. DATE THEREOF <u>Nov. 21, 1967</u>					
23c. NAME OF CEMETERY OR CREMATORY <u>St. Josephs Cem.</u>						23d. LOCATION (City, town or county) (State) <u>Taunton, Massachusetts</u>					
24. FUNERAL DIRECTOR'S SIGNATURE <u>H. J. Ehrhardt</u> ADDRESS <u>Owings Mills, Md.</u>						25a. REC'D BY REGISTRAR <u>NOV 20 1967</u> 25b. REGISTRAR'S SIGNATURE <u>W. J. ...</u>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

14895

# MARYLAND STATE DEPARTMENT OF HEALTH

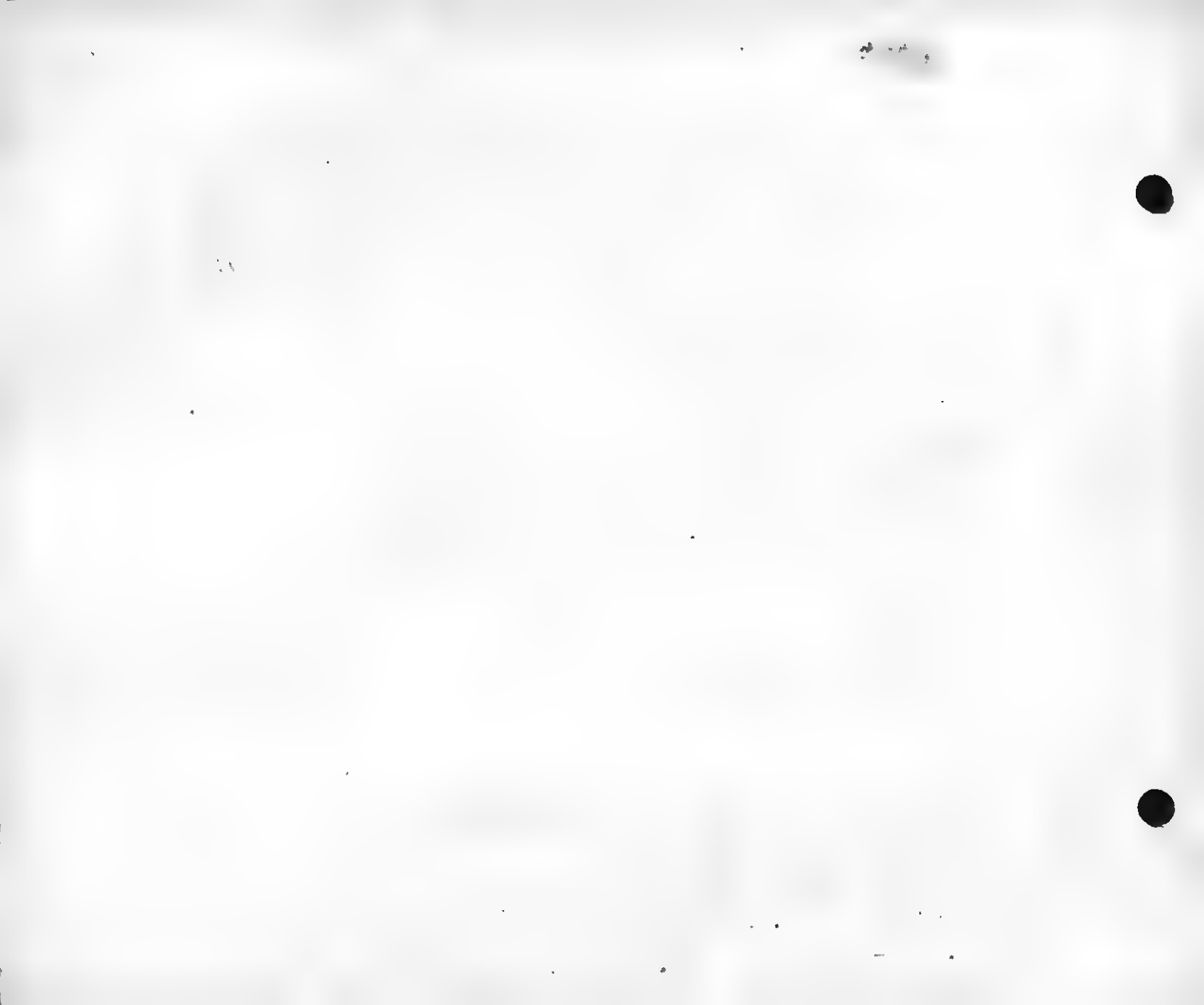
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

14895

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Towson</u>		c. LENGTH OF STAY IN ID <u>35 Days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Greater Baltimore Medical Center</u>		e. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Towson</u>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Henry</u> Last <u>Brady</u>		4. DATE OF DEATH Month <u>Nov</u> Day <u>4</u> Year <u>1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/24/17</u>
9. AGE (In years last birthday) <u>50</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Chassis Filer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>social security admin</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>John A. Brady</u>		14. MOTHER'S MAIDEN NAME <u>Isabel T. Paca</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u>		16. SOCIAL SECURITY NO. <u>217-01-2481</u>	
17. INFORMANT <u>Physician</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio respiratory failure</u> 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <u>Myocardial infarction</u> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>11-2</u> , 19 <u>67</u> , to <u>11-4</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>11-4</u> , 19 <u>67</u> , and that death occurred at <u>10 P.M.</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Rahim M. Basiri</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Nov. 8, 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Dulaney Valley Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Cockeysville, Maryland</u>	
24. FUNERAL DIRECTOR <u>Wm. Cook-Brooks Towson</u>		25a. REC'D BY REGISTRAR <u>NOV 8 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		25c. ADDRESS <u>Towson, Maryland 21204</u>	

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14896

CERTIFICATE OF DEATH

14892

1 PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Pikesville</b>		c. LENGTH OF STAY IN 1b <b>20 yrs.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>4233 Millora Mill Rd., Pikesville 8, Md.</b>		e. STREET ADDRESS <b>4233 Millora Mill Rd.</b>	
3 NAME OF DECEASED (Type or print) <b>Joseph Francis Branick</b>		4 DATE OF DEATH Month <b>Nov.</b> Day <b>18,</b> Year <b>1967</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 17, 1897</b>
9. AGE (In years last birthday) <b>70 yrs</b>		10. IF UNDER 1 YEAR Months <b>11</b> Days <b>11</b> Hours <b>5</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Chief Clerk R. Exp.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Railway Express</b>	
11 BIRTHPLACE (County & State, or foreign country) <b>Baltimore, Md.</b>		12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Frank S. Branick</b>		14. MOTHER'S MAIDEN NAME <b>Frances Gibold</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>one</b>	
17. INFORMANT <b>Mrs. Bertha L. Branick, 4233 Millora Mill Rd.</b>		Address <b>Pikesville, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <b>1992</b> IMMEDIATE CAUSE (a) <b>Carcinoma of the bladder - metastasizing to</b> DUE TO <b>and</b> (b) <b>Carcinoma of the lung - metastasizing to</b> DUE TO <b>5 m</b> (c) <b>lost</b>		INTERVAL BETWEEN ONSET AND DEATH <b>11 m</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour <b>o.m.</b> 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>1962</b> to <b>18 Nov. 1967</b> , that (I) (we) last saw the deceased alive on <b>16 Nov. 1967</b> , and that death occurred at <b>5:24 AM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>Douglas Lockard</b>		22b. DATE SIGNED <b>20 Nov. 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>J. Douglas Lockard, M.D.</b>		22d. ADDRESS <b>Lockey's Mill Rd., Pikesville, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>Nov 21, 1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Baltimore 11, Md.</b>
24. FUNERAL DIRECTOR <b>Frank H. Newell, Pikesville</b>		25. REC'D BY REGISTRAR <b>NOV 21 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>John J. Judge</b>			





## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14897

14903

FOR STATE  
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a COUNTY <b>Baltimore County</b> MARYLAND		2 USUAL RESIDENCE (If deceased lived in institution, Residence before admission) a STATE <b>Maryland</b> b COUNTY <b>Baltimore</b> c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>St. Joseph's Hospital</b>		d STREET ADDRESS <b>1831 White Oak Ave</b>	
3. NAME OF DECEASED (Type or print) <b>Mary Bence Ellen Mary Bence</b>		4. DATE OF DEATH <b>Nov. 23 1967</b>	
5 SEX <b>Female</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>2/6/1900</b> 9 AGE (In years last birthday) <b>67</b>
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Book Keeper</b>		10b KIND OF BUSINESS OR INDUSTRY <b>Internal Revenue</b>	
11 BIRTHPLACE (State or foreign country) <b>Maryland</b>		12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13 FATHER'S NAME <b>Thomas Murphy</b>		14 MOTHER'S M maiden name <b>Mary A White</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>215-05-6600</b>	
17 INFORMANT <b>Mr G. Allan Bence</b>		Address <b>4519 Keswick Rd</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> DUE TO (b) <b>Hyper tension</b> DUE TO (c) <b>Cardio Vascular Disease</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town, (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Charles F. O'Donnell, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Charles F. O'Donnell, M.D.</b>		ASSISTANT MED. CAL. EXAMINER <input type="checkbox"/>	
		DEPUTY MED. CAL. EXAMINER <input type="checkbox"/>	
		Address (Street, city, town, or county)	
23a BURIAL (CREMATION REMOVAL) (Specify) <b>Burial</b>	23b DATE THEREOF <b>11/27/67</b>	23c NAME OF CEMETERY OR CREMATORY <b>New Cathedral</b>	23d LOCATION (City or town) (County) (State) <b>Baltimore Md</b>
24 FUNERAL DIRECTOR <b>Leonard J Ruck Inc</b>		25a REC'D BY REGISTRAR <b>NOV 24 1967</b>	
ADDRESS <b>5305 Harford Rd</b>		25b REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

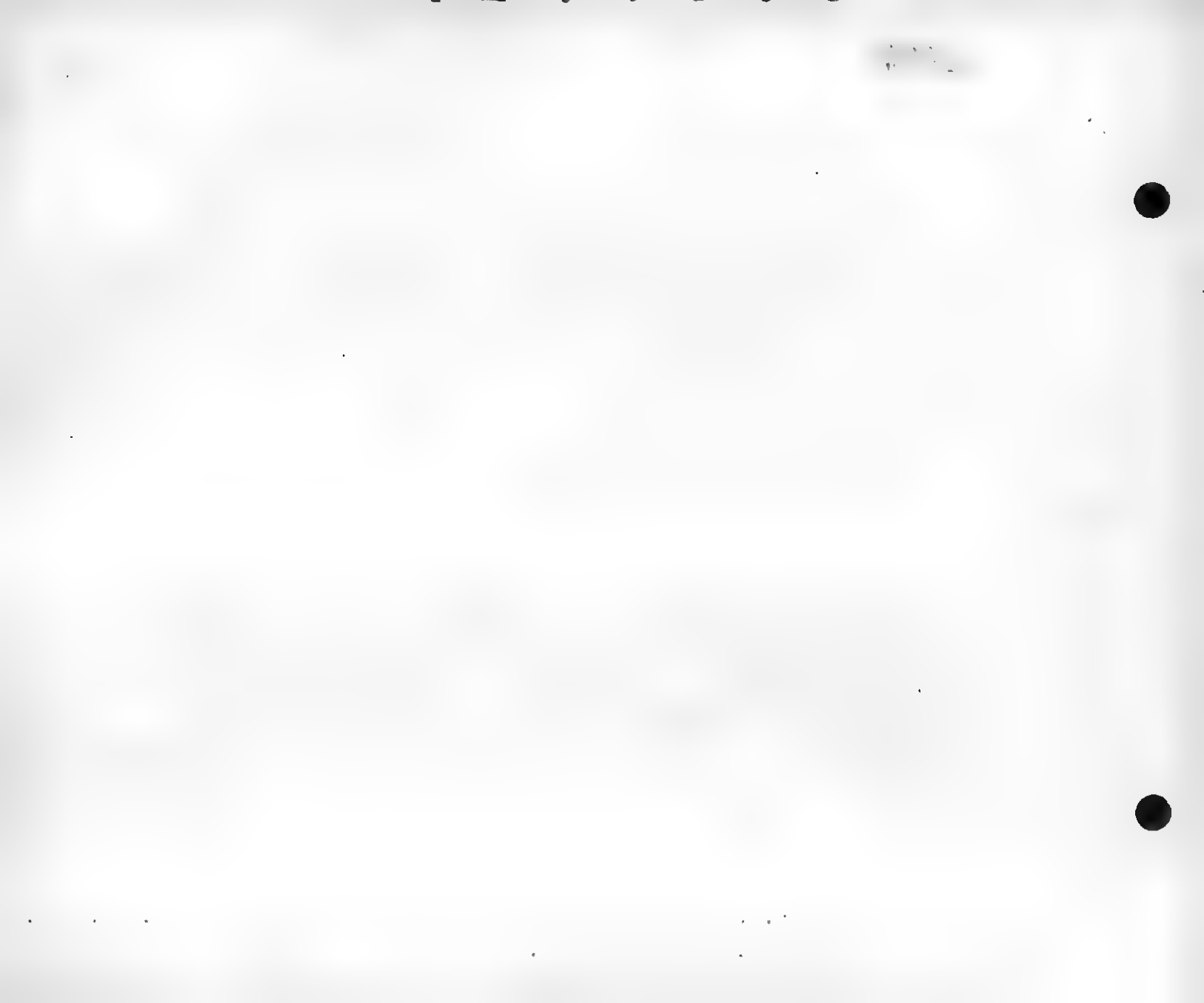
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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>IRIDURAH Towson 4</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>IRIDURAH Joppa 11</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>GREATER BALTIMORE MEDICAL CENTER</b>		d. STREET ADDRESS <b>105 Joppa Farm Road</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>KIMBERLY DAWN BURK</b>		4. DATE OF DEATH Month Day Year <b>11 4 1967</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10/23/67</b>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		9b. AGE (In years last birthday) Months Days Hours Min. <b>— — 12</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>BALTIMORE, M-D.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>ROBERT GEORGE BURK</b>		14. MOTHER'S MAIDEN NAME <b>Ann Virginia BARKER</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>—</b>	
17. INFORMANT (Name and Address) <b>Robert G. Burk, 105 Joppa Farm Rd., Joppa, Md.</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ASPIRATION PNEUMONIA</b> DUE TO (b) <b>1650</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <b>11 hrs.</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>11-3</b> , 19 <b>67</b> , to <b>11-4</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>11-4</b> , 19 <b>67</b> , and that death occurred at <b>5 AM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Lilia C. Baldonado</b>		22b. DATE SIGNED <b>11-4-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>LILIA C. BALDONADO</b>		22d. ADDRESS <b>- G B M C -</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>Nov. 7, 1967</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Woodlawn, Balto., Co., Md.</b>	
24. FUNERAL DIRECTOR <b>STEWART &amp; MOWEN CO., 108 W. North Av., Balto.</b>		25a. REC'D BY REGISTRAR <b>NOV 7 1967</b>	
		25b. REGISTRAR'S SIGNATURE <b>J. Charles Jones</b>	



14898

CERTIFICATE OF DEATH

14905

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

(M)

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>Florida</b> b. COUNTY <b>V</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Jacksonville</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>St. Joseph Hospital, Towson, Md. 21204</b>		d. STREET ADDRESS <b>6182 Chester Avenue</b>	
3. NAME OF DECEASED (Type or print) <b>Baby Boy BURTON</b>		4. DATE OF DEATH Month <b>November</b> Day <b>24</b> Year <b>67</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11-23-67</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Cube</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore, Maryland</b>	
13. FATHER'S NAME <b>James Burton</b>		14. MOTHER'S MAIDEN NAME <b>Iris Hofferberth</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Parents</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Prematurity - Atelectasis</b> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>8</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) _____ (County) _____ (State) _____		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that (I) (this hospital) attended the deceased from <b>11-23-67</b> , 19 <b>11-24</b> , 19 <b>67</b> , that (I) (we) lost saw the deceased alive on <b>11-24</b> , 19 <b>67</b> , and that death occurred on <b>NOON</b> M, from causes on and on the date stated above.			
22a. SIGNATURE <i>Jose A. Aguto</i>		22b. DATE SIGNED <b>11-24-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Jose A. Aguto</b>		22d. ADDRESS <b>7620 York Road, Baltimore, Maryland 21204</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
<b>Removal (Specify)</b>	<b>Nov. 27, 1967</b>	<b>Riverside Memorial Park</b>	<b>Jacksonville, Florida</b>
24. FUNERAL DIRECTOR <i>John Bruno Sons</i>		25a. REC'D BY REGISTRAR <i>Locoson, Md.</i>	
25b. REGISTRAR'S SIGNATURE <i>Charles Jones</i>		DATE <b>NOV 28 1967</b>	

621



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Dundalk</b>		c. LENGTH OF STAY IN 1b <b>16 Months</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Baltimore</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Dundalk</b>		d. STREET ADDRESS <b>2005 Kelmores Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Joshua</b>		First <b>Joshua</b>		Middle <b>H.</b>		Last <b>Busch</b>		4. DATE OF DEATH Month <b>November</b>		Day <b>29</b>		Year <b>19 67</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1/20/73</b>		9. AGE (in years last birthday) <b>94 yrs.</b>		IF UNDER 1 YEAR Months <b>94</b>		Days <b>29</b>		Hours <b>19</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) <b>Meter Maker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Md. Meter Works</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>									
13. FATHER'S NAME <b>Not Known</b>		14. MOTHER'S MAIDEN NAME <b>? Ellen</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>212-56-5944</b>		17. INFORMANT (Daughter) <b>Mrs. Alma Fifer, 2005 Kelmores Rd. Dundalk,</b>		Address <b>Md. 21222</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c)		19. INTERVAL BETWEEN ONSET AND DEATH <b>5 YRS</b>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <b>11/20/67</b> , 19 <b>67</b> , to <b>11/29/67</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>11/24/67</b> , 19 <b>67</b> , and that death occurred at <b>9:04 AM</b> , from the causes and on the date stated above.		22a. SIGNATURE <b>W. E. Baermann</b>		22b. DATE SIGNED <b>11/30/67</b>		22c. PHYSICIAN'S NAME (Type) <b>W. E. Baermann</b>		22d. ADDRESS <b>M. D. 3401 Dundalk Ave. Dundalk, Md. 21222</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12/2/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Baltimore, Md.</b>		24. FUNERAL DIRECTOR <b>John J. Duda, 7922 Wise Ave. Dundalk, Md.</b>		25a. REC'D BY REGISTRAR <b>DEC 4 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			





MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14907

14901

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution on Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>1</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>Catonsville</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Summitt Nursing Home</u>		d. STREET ADDRESS <u>6120 Wheatland Rd. - Westview</u>	
3. NAME OF DECEASED (Type or print) <u>Catherine Sullivan Busey</u>		4. DATE OF DEATH Month <u>Nov.</u> Day <u>3</u> Year <u>1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>Cauc.</u>	7. MARRIED <input type="checkbox"/> <u>NEVER MARRIED</u> <u>WIDOWED</u> <input checked="" type="checkbox"/> <u>DIVORCED</u> <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>1/20/96</u>
9. AGE (In years and months) <u>71</u> yrs		10. IF UNDER 1 YEAR Months <u>1</u> Days <u>1</u> Hours <u>1</u> Min. <u>1</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Saleslady</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Sullivan</u>		14. MOTHER'S MAIDEN NAME <u>-----</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mrs. John R. Pelton</u> <u>6120 Wheatland Rd. - 21228</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH CAUSED BY <u>1750</u> IMMEDIATE CAUSE (a) <u>Carcinomatosis Generalized</u> DUE TO (b) <u>Adeno-Carcinoma of ovary</u> DUE TO (c) <u>-----</u>		INTERVAL BETWEEN ONSET AND DEATH <u>7 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>1960 to Oct 3, 1967</u> that (I) (we) last saw the deceased alive on <u>Oct 3, 1967</u> and that death occurred at <u>11:50 AM</u> from causes and on the date stated above.			
22a. SIGNATURE <u>D. P. Alagia</u>		22b. DATE SIGNED <u>11/4/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>D. P. Alagia, M. D.</u>		22d. ADDRESS <u>3326 Frederick Ave.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>11/6/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cem.</u>	23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Md.</u>
24. FUNERAL DIRECTOR <u>Witzke F. D. - 4101 Edmondson Ave.</u>		25a. REC'D BY REGISTRAR DATE <u>NOV 6 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

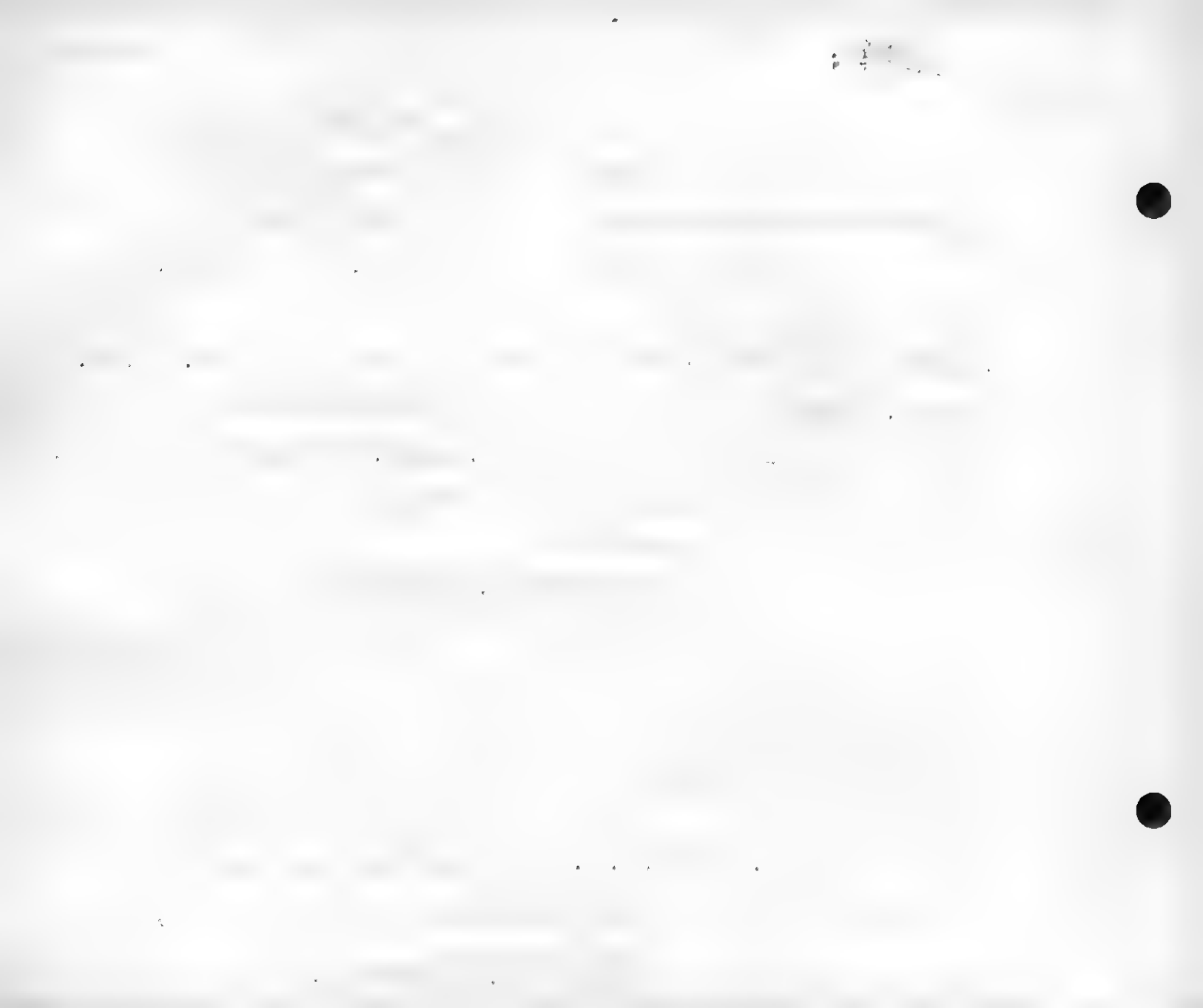
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if not in on. Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>		c. LENGTH OF STAY IN 1b <b>9 DAYS</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>VETERANS ADMINISTRATION HOSPITAL</b>		e. STREET ADDRESS <b>750 MC KEWIN AVENUE</b>	
3 NAME OF DECEASED (Type or print) First <b>JOHN</b> Middle <b>BERNARD</b> Last <b>CARMINE, SR.</b>		4 DATE OF DEATH Month <b>NOVEMBER</b> Day <b>17</b> Year <b>19 67</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>11/9/23</b>
9. AGE (In years last birthday) <b>44</b> yrs		10. UNDER 1 YEAR <input type="checkbox"/> 11. UNDER 24 HRS <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>ELECTRICAL MAINTENANCE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>BLACK &amp; DECKER TOOL CO NORTH LINTHICUM, MD.</b>	
11. BIRTHPLACE (County & State or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>EARLE J. CARMINE</b>		14. MOTHER'S MAIDEN NAME <b>MARY ALICE BURNESTON</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>YES WW II</b>		16. SOCIAL SECURITY NO <b>212 18 40 01</b>	
17. INFORMANT <b>CLIN. RECORDS, VA HOSPITAL FT HOWARD, MD.</b>		18. CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>BRAIN ABSCESSSES, MULTIPLE</b> Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) <b>BRONCHOPNEUMONIA</b> (c) <b>LYMPHATIC LEUKEMIA, TREATED, OLD</b>	
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1B)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (he)(this hospita) attended the deceased from <b>11/9/67</b> , 19 to <b>11/17/67</b> , 19, that (s) (we) last saw the deceased alive on <b>11/17/67</b> , 19, and that death occurred at <b>6:30A</b> AM, from causes and on the date stated above.			
22a. SIGNATURE <b>John D. Talbert</b>		22b. DATE SIGNED <b>11/17/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>JOHN D. TALBERT, M. D.</b>		22d. ADDRESS <b>VAH FORT HOWARD, MARYLAND</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>11/20/1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>LOUDEN PARK NATIONAL CEMETERY</b>	23d. LOCATION (City or town) (County) (State) <b>BALTIMORE, MARYLAND</b>
24. FUNERAL DIRECTOR <b>HENRY W. JENKINS FUNERAL HOME</b> <b>(21212)</b>		25a. REC'D BY REGISTRAR <b>NOV 20 1967</b> 25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14902

CERTIFICATE OF DEATH

14909

1 PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>5310 Hillen Rd.</u>	
c. LENGTH OF STAY IN 1b <u>10 days</u>		d. STREET ADDRESS <u>5310 Hillen Rd.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Greater Baltimore Medical Center</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <u>Samuel NMN Carnevale</u>		4 DATE OF DEATH Month <u>11</u> Day <u>19</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Can</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/1/86</u>
9. AGE (In years lost birthday) <u>81</u> yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unknown</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Unknown</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Bari, Italy</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Francesco Carnevale</u>		14. MOTHER'S M maiden name <u>De Bellis</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> <u>1918</u>		16. SOCIAL SECURITY NO. <u>214-18-7103</u>	
17. INFORMANT <u>Patient's Chart</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))			
PART I. DEATH CAUSED BY:			
IMMEDIATE CAUSE (a) <u>Cardiac decompensation - acute + Chronic</u>			
DUE TO (b) <u>myocardial infarction - Hypertension</u>			
DUE TO (c) <u>arteriosclerotic Cardiovascular disease</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c)			
<u>Pneumonia</u> - <u>Peptic ulcer</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <u>it</u> (this hospital) attended the deceased from <u>Nov 9</u> , 19 <u>67</u> , to <u>Nov 19</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Nov 19</u> , 19 <u>67</u> , and that death occurred at <u>8:00</u> AM, from causes and on the date stated above.			
22a. SIGNATURE <u>T.C. Cullis MD</u>		22b. DATE SIGNED <u>19-Nov-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>T.C. Cullis MD</u>		22d. ADDRESS <u>Greater Balt. Medical Center</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer</u>	23d. LOCATION (City or Town) (County) (State) <u>4430 Belair Rd. Balt. Md</u>
24. FUNERAL DIRECTOR <u>Frank Della Noce</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
ADDRESS <u>4000 322 S. High</u>		DATE <u>NOV 20 1967</u>	



14904

CERTIFICATE OF DEATH

14010

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed in the funeral director's office. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Halethorpe</u>		c. LENGTH OF STAY IN 1b <u>18 yrs.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>4625 Magnolia Ave</u>		d. STREET ADDRESS <u>4625 Magnolia Ave.</u>	
3. NAME OF DECEASED (Type or print) <u>Amy B. Carter</u>		4. DATE OF DEATH Month <u>11</u> Day <u>23</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/6/99</u>
9. AGE (In years last birthday) <u>68</u> yrs		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (County & State or foreign country) <u>England</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Alfred Martin</u>		14. MOTHER'S MAIDEN NAME <u>Amy Mules</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>  </u>	
17. INFORMANT <u>Amy Pugh</u>		Address <u>4625 Magnolia Ave.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Carcinoma Left Breast</u> 170X DUE TO (b) <u>Metastases -</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c) <u>  </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>  </u> a.m. <u>  </u> p.m. <u>  </u> 19 <u>  </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>1962</u> to <u>Nov 23, 1967</u> , that (I) (we) last saw the deceased alive on <u>Nov 22, 1967</u> , and that death occurred at <u>4A</u> M, from causes and on the date stated above			
22a. SIGNATURE <u>Frederick D. Beiter</u>		22b. DATE SIGNED <u>  </u>	
22c. PHYSICIAN'S NAME (Type) <u>Frederick Beiter</u>		22d. ADDRESS <u>1014 Francis Ave.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>11/27/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Balto. National Cem.</u>	23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Maryland</u>
24. FUNERAL DIRECTOR <u>Ambrose Inc. 1329 Sulphur Sp. Rd.</u>		25a. REC'D BY REGISTRAR DATE <u>NOV 27 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>  </u>	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14903

CERTIFICATE OF DEATH

16462

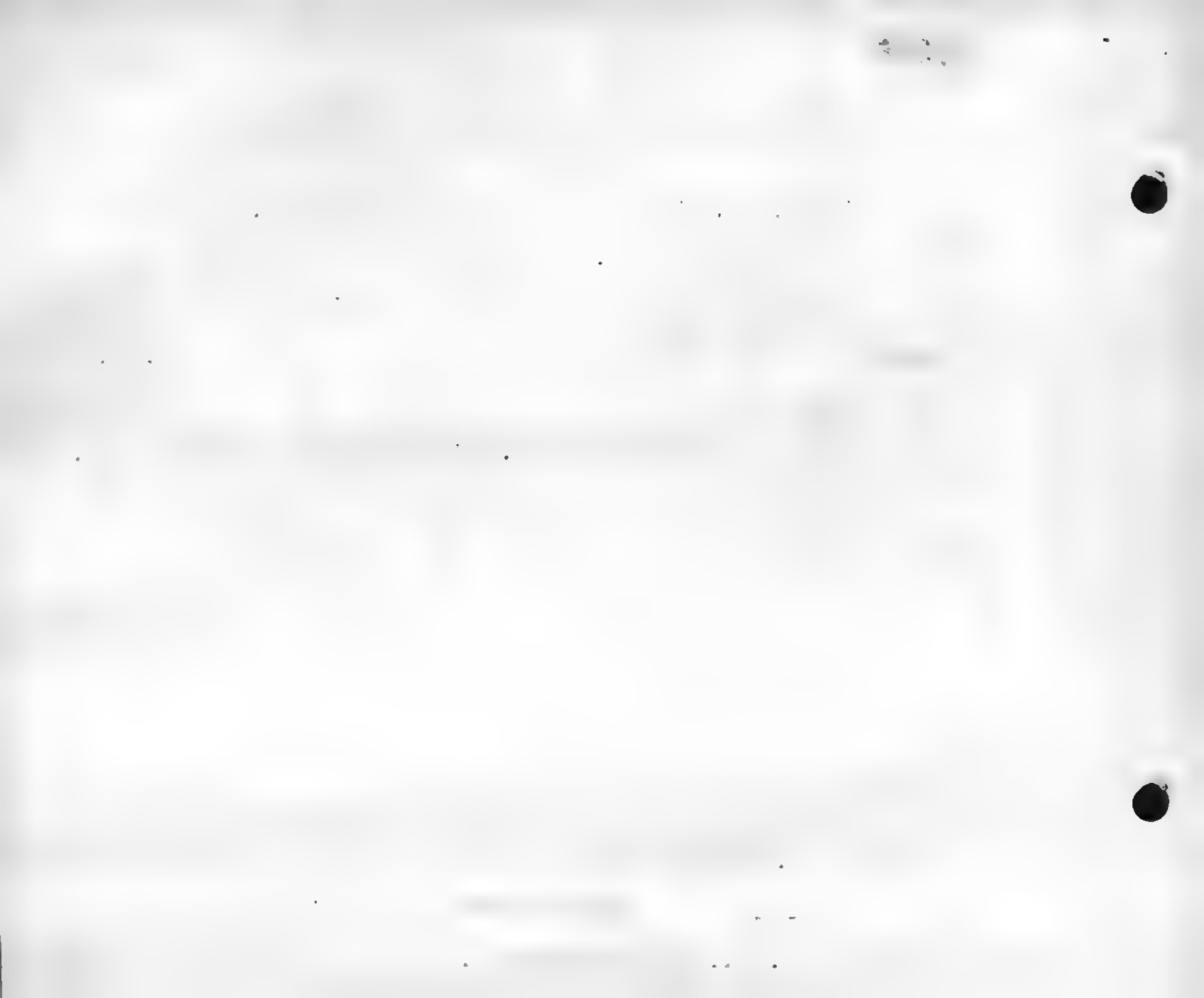
1 PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b> c. LENGTH OF STAY IN 1b <b>15 DAYS</b>				2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b> d. STREET ADDRESS <b>2262 LINDEN AVENUE</b> e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First Middle Last <b>ARMSTEAD M. CARTER</b>				4. DATE OF DEATH Month Day Year <b>NOVEMBER 29 19 67</b>			
5 SEX <b>MALE</b>	6. COLOR OR RACE <b>NEGRO</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9/7/95</b>		9 AGE (In years last birthday) <b>72 yrs.</b>	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LONGSHOREMAN</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>SHIPPING</b>		11 BIRTHPLACE (County & State, or foreign country) <b>RICHMOND, VIRGINIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>CORNELIUS CARTER</b>				14. MOTHER'S MAIDEN NAME <b>MARIA FLEMING</b>			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>YES WW I</b>		16 SOCIAL SECURITY NO <b>214 05 35 21</b>		17. INFORMANT Address <b>CLIN.RECORDS, VA HOSPITAL, FT HOWARD, MD.</b>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>HEMORRHAGE, MASSIVE GASTRO INTESTINAL</b> DUE TO (b) <b>ADENOCARCINOMA PROSTATE</b> DUE TO (c) (Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.)						INTERVAL BETWEEN ONSET AND DEATH <b>RECENT</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>PULMONARY INFARCTION, RECENT. PULMONARY CONGESTION &amp; EDEMA</b>						19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)		
21 I certify that (1) this hospital attended the deceased from <b>11/14/67</b> , 19 <b>67</b> , to <b>11/29/67</b> , that (2) (we) last saw the deceased alive on <b>11/29/67</b> , 19 <b>67</b> , and that death occurred at <b>5:45PM</b> , from causes and on the date stated above							
22a. SIGNATURE <i>George C. McElpatrick</i> 22c PHYSICIAN'S NAME (Type) <b>GEORGE C. MC ELPATRICK, M. D.</b>				ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/> 22b DATE SIGNED <b>11/30/67</b>		22d ADDRESS <b>VAH FORT HOWARD, MARYLAND</b>	
23a BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b DATE THEREOF <b>12-4-67</b>	23c NAME OF CEMETERY OR CREMATORY <b>BALTIMORE NATIONAL</b>		23d LOCATION (City or Town) (County) (State) <b>BALTIMORE, MARYLAND</b>		
24 FUNERAL DIRECTOR <i>Charles S. Law</i> <b>CHARLES S. LAW</b>			ADDRESS <b>147 FUNERAL HOME 802 N. MADISON AVE. BALTIMORE, MD.</b>		25a RECD BY REGISTRAR <b>DEC 6 1967</b>	25b REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH																			
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND																			
14906 CERTIFICATE OF DEATH 14017																			
1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY														
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Pikesville</b>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b>														
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>11 SLADE AVENUE, APT. 711</b>					d. STREET ADDRESS <b>11 SLADE AVENUE, APT. 711 #21208</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>											
3. NAME OF DECEASED (Type or print) First <b>EMANUEL</b> Middle <b>G.</b> Last <b>CARTON</b>		4. DATE OF DEATH Month <b>NOVEMBER</b> Day <b>24</b> Year <b>1967</b>		5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>											
8. DATE OF BIRTH <b>FEBRUARY 18, 1912</b>		9. AGE (in years last birthday) <b>55</b> yrs.		10. FINDER 1 YEAR Months <b>55</b> Days <b>55</b> Hours <b>55</b> Min.		11. BIRTHPLACE (County & State, or foreign country) <b>RUSSIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>											
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>ATTORNEY</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>SELF EMPLOYED</b>			13. FATHER'S NAME <b>EDWARD CARTON</b>			14. MOTHER'S MAIDEN NAME <b>ESTHER ?</b>										
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>			16. SOCIAL SECURITY NO. <b>215-28-8770</b>			17. INFORMANT <b>MRS. SELMA CARTON, 11 SLADE AVENUE, APT. 711</b>			Address										
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of lung</b> DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>none</b> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.			20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)										
21. I certify that (I) (this hospital) attended the deceased from <b>Nov 11/23 1967</b> to <b>present</b> 19 <b>1967</b> , that (I) (we) last saw the deceased alive on <b>11/23 1967</b> , and that death occurred at <b>2:35 AM</b> , from the causes and on the date stated above.																			
22a. SIGNATURE <b>Bernard Burgin</b>					22b. DATE SIGNED <b>11/24/67</b>														
22c. PHYSICIAN'S NAME (Type) <b>DR. BERNARD BURGIN</b>					22d. ADDRESS <b>6721 Reisterstown Rd. Balto. Md.</b>														
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>			23b. DATE THEREOF <b>11-24-67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>BALTIMORE HEBREW</b>			23d. LOCATION (City, town or county) (State) <b>BALTIMORE, MARYLAND</b>											
24. FUNERAL DIRECTOR <b>SOL LEVINSON &amp; BROS. INC., 6010 REISTERSTOWN RD.</b>					25a. REC'D BY REGISTRAR <b>NOV 28 1967</b>					25b. REGISTRAR'S SIGNATURE <b>Charles</b>									

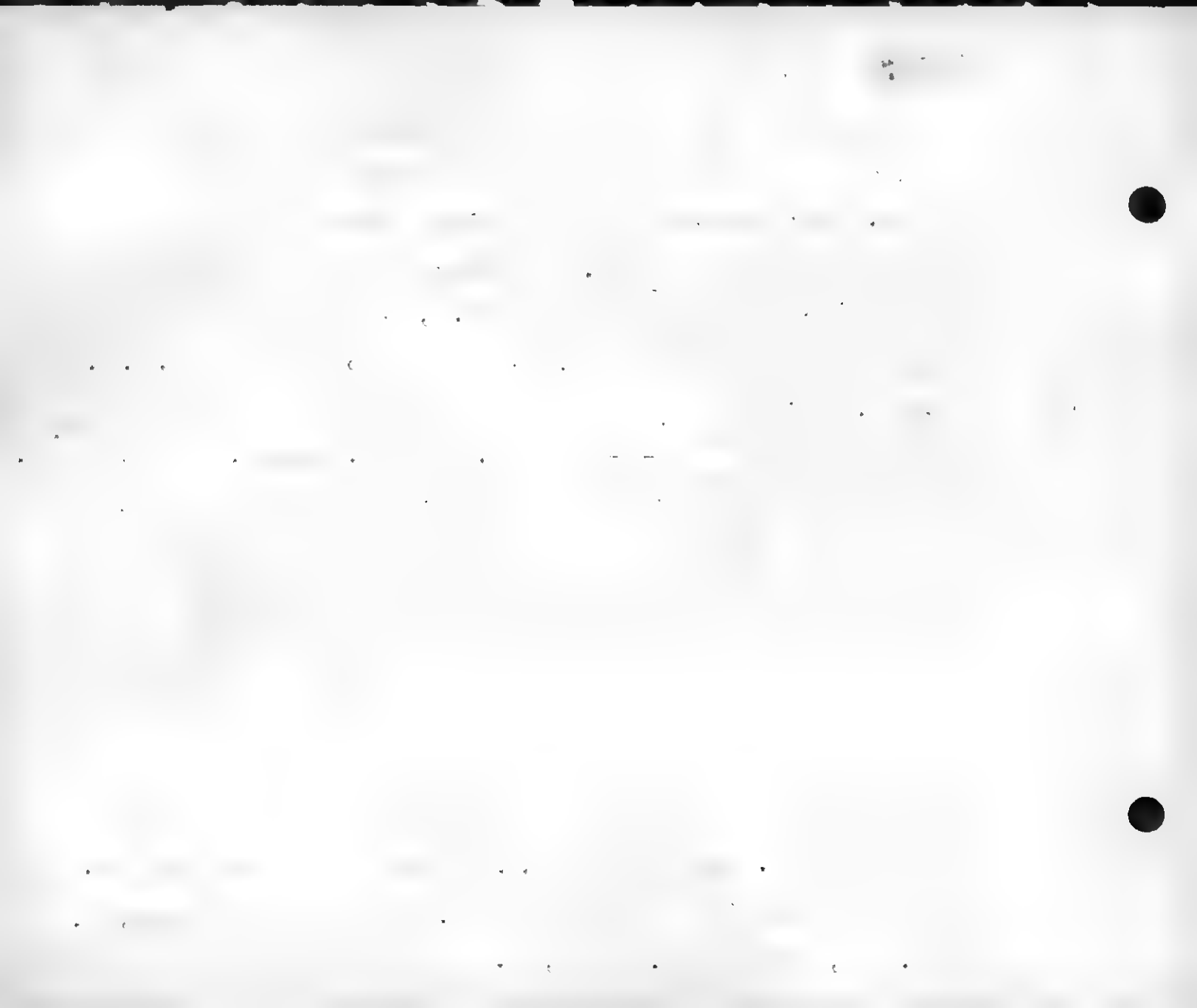


1  
-2  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

14907

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b> c. LENGTH OF STAY IN 1b <b>Hours</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>St. Joseph Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dundalk</b> d. STREET ADDRESS <b>1704 Holaview Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>F.</b> Last <b>Cassiday</b>		4. DATE OF DEATH Month <b>November</b> Day <b>23</b> Year <b>1967</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 5, 1911</b>
9. AGE (In years last birthday) <b>56</b> yrs.		10. IF UNDER 1 YEAR Months <b>56</b> Days <b>56</b> Hours <b>56</b> Min. <b>56</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Principal</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Overlea High School</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Iowa</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Robert C. Cassiday</b>		14. MOTHER'S MAIDEN NAME <b>Nellie LaMay</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes give war or dates of service) <b>WWII</b>		16. SOCIAL SECURITY NO. <b>484-09-0004</b>	
17. INFORMANT (Wife) <b>Mrs. Frances E. Cassiday</b>		Address <b>Dundalk, Md.</b> <b>1704 Holaview Rd.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ACUTE CORONARY OCCLUSION</b> DUE TO (b) <b>MYOPEXTENSION</b> DUE TO (c) <b>MYOPEXTENSION</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <b>1 HOUR</b> <b>YEARS.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year <b>19</b> Hour <b>a.m.</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (1) (this hospital) attended the deceased from <b>NOV 23, 1967</b> to <b>NOV 23, 1967</b> , that (1) (we) last saw the deceased alive on <b>NOV 23, 1967</b> , and that death occurred at <b>3P.</b> M, from the causes and on the date stated above.			
22a. SIGNATURE <b>Luis J. Elias</b>		22b. DATE SIGNED <b>11/24/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Luis J. Elias</b>		22d. ADDRESS <b>Northern Pkwy &amp; Loch Raven Blvd.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11/27/67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Dulaney Valley Mem. Gardens</b>		23d. LOCATION (City, town or county) (State) <b>Cockeysville, Md.</b>	
24. FUNERAL DIRECTOR <b>John J. Duda</b>		25a. REC'D BY REGISTRAR <b>NOV 27 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>John J. Duda</b>			



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If city delay is necessary, please execute the certificate writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the local health department of the health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT.

14908

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14913

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Owings Mills</b>		c. LENGTH OF STAY IN Tb <b>12 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Laurel</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Rosewood State Hospital</b>				d. STREET ADDRESS <b>41 Bruce Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Franklin Edward CASTLE, Jr.</b>				4. DATE OF DEATH Month <b>11</b> Day <b>17</b> Year <b>19 67</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>11-1-54</b>		9. AGE (In years last birthday) <b>13</b> yrs	IF UNDER 1 YEAR Months Days Hours M.in.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Dependent</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>none</b>		11. BIRTHPLACE (State or foreign country) <b>Millington, Tennessee</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Franklin Edward Castle, Sr.</b>				14. MOTHER'S MAIDEN NAME <b>Barbara Jean Fletcher</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>Rosewood Records, Owings Mills, Maryland</b>			
B. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Asphyxia due to Food Aspiration</b> 2217 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Muscular Dystrophy</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>25 min.</b> <b>13 yrs.</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>None</b>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item B) <b>Aspirated food.</b>			
20c. TIME OF INJURY Month, Day Year <b>9:20 a.m. 11/17 19 67</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street office bldg., etc.) <b>Hosp. Annex East</b>		20f. (City or town) (County) (State) <b>Owings Mills Balto. Md.</b>	
21. I certify that I took charge of the remains described above held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from. Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>D. D. Caples</b> EXAMINER'S NAME (Type) <b>D. D. Caples, M.D.</b>				22. DATE SIGNED <b>11/17/67</b> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <b>Reisterstown, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11-20-67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Trinity Hill Cem</b>		23d. LOCATION (City or town) (County) (State) <b>Laurel Md</b>	
24. FUNERAL DIRECTOR <b>De Witt Donahoe</b>				25a. REC'D BY REGISTRAR <b>Nov 22 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles</b>	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
14908									
1. PLACE OF DEATH a. COUNTY <u>Baltimore Co</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>BALTIMORE</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pikesville</u>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE, Md. 21215</u>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Milford Manor NURSING HOME</u>					d. STREET ADDRESS <u>4956 EDMERE AVE.</u>				
3. NAME OF DECEASED (Type or print) <u>Rose V. Pesko</u>					4. DATE OF DEATH Month <u>11</u> Day <u>3</u> Year <u>1967</u>				
5. SEX <u>FEMALE</u>					6. COLOR OR RACE <u>WHITE</u>				
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>					8. DATE OF BIRTH <u>9-15-02</u> 65 yrs.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SELF EMPLOYED</u>					10b. KIND OF BUSINESS OR INDUSTRY <u>GROCERY STORE</u>				
11. BIRTHPLACE (County & State or foreign country) <u>CLYNDON, MARYLAND</u>					12. CITIZEN OF WHAT COUNTRY <u>U.S.</u>				
13. FATHER'S NAME <u>WILLIAM SHEER</u>					14. MOTHER'S MAIDEN NAME <u>JENNIE</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>					16. SOCIAL SECURITY NO. <u>212-36-7984</u>				
17. INFORMANT <u>Charles Peska</u>					23. DEATH AND DRIVE <u>23 DEACON DRIVE</u>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Cancer of Stomach</u> 151X DUE TO (b) <u>Undifferentiated Cancer of Stomach</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH <u>9 mos</u> <u>15 mos</u>				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OF CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)									
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>									
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>									
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)									
20f. (City or town) (County) (State)									
21. I certify that (I) (this hospital) attended the deceased from <u>June 1958</u> to <u>Nov 3, 1967</u> , that (I) (we) last saw the deceased alive on <u>Nov 2, 1967</u> , and that death occurred at <u>4 P.M.</u> from the causes and on the date stated above.									
22a. SIGNATURE <u>Jonas Cohen</u> M.D.									
22b. DATE SIGNED <u>Nov 3, 1967</u>									
22c. PHYSICIAN'S NAME (Type) <u>JONAS COHEN</u>									
22d. ADDRESS <u>6707 Park Heights Ave. BALTO. Md.</u>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>									
23b. DATE THEREOF <u>11-5-67</u>									
23c. NAME OF CEMETERY OR CREMATORY <u>BALTIMORE HEBREW</u>									
23d. LOCATION (City, town or county) (State) <u>BALTIMORE, MARYLAND</u>									
24. FUNERAL DIRECTOR'S SIGNATURE <u>SOL LEVINSON &amp; BROS. INC.</u> ADDRESS <u>6010 DEISTERSTOWN RD.</u>									
25a. REC'D BY REGISTRAR <u>Charles Judge</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>									
DATE <u>NOV 9 1967</u>									



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VR A15 (4)  
20M 1/65

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
CERTIFICATE OF DEATH										
1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>TOWSON</b> c. LENGTH OF STAY IN 1b <b>39 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>GREATER BALTIMORE MEDICAL CENTER</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>—</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b> d. STREET ADDRESS <b>909 E. BELVEDERE AVE.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <b>HELEN</b> Middle <b>TERRELL</b> Last <b>CHESNEY</b>			4. DATE OF DEATH Month <b>11</b> Day <b>21</b> Year <b>1967</b>		5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>CAU.</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>		11. BIRTHPLACE (County & State, or foreign country) <b>BALTO., MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>EMBRAT TERRELL DEC.</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>			16. SOCIAL SECURITY NO. <b>24-40-4606-B</b>		17. INFORMANT <b>PHO HISTORY</b>		18. MOTHER'S MAIDEN NAME <b>EMMA BOWIE</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiopulmonary failure.</b> DUE TO (b) <b>Adenocarcinoma uteri with metastasis</b> DUE TO (c) <b>and atherosclerotic cardiovascular disease</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)										
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <b>10-12-1967</b> to <b>11-21-1967</b> , that (I) (we) last saw the deceased alive on <b>11-20-1967</b> , and that death occurred at <b>5-9 PM</b> , from the causes and on the date stated above.	
22a. SIGNATURE <b>Dipak Kumar Mallik</b>					22b. DATE SIGNED <b>11-21-67</b>		22c. PHYSICIAN'S NAME (Type) <b>DIPAK KUMAR MALLIK</b>		22d. ADDRESS <b>Greater Baltimore Medical Center</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE THEREOF <b>11/24/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park</b>		23d. LOCATION (City, town or county) (State) <b>Baltimore, Md.</b>		25a. REC'D BY REGISTRAR <b>NOV 21 1967</b>	
24. FUNERAL DIRECTOR <b>H.W. Jenkins &amp; Sons Co. 4905 York Road Balto., Md. 21212</b>					25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>					



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VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14911

14016

1 PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>		c LENGTH OF STAY IN 1b <b>Weeks</b> <b>Baldwin</b>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Chesapeake Nursing Home</b>		d STREET ADDRESS <b>Box 261 Carroll Manor Rd.</b>	
3 NAME OF DECEASED (Type or print) <b>AMELIA CHIAPPETTA</b>		4. DATE OF DEATH Month <b>Nov.</b> Day <b>13,</b> Year <b>1967</b>	
5 SEX <b>Female</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>Sept. 25, 1918</b>
9. AGE (in years lost, birthday) <b>49 yrs</b>		IF UNDER 1 YEAR Months <b>1</b> Days <b>13</b> Hours <b>13</b> Min <b>13</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>INDUSTRY</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>New York</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Mario Serenati</b>		14. MOTHER'S MAIDEN NAME <b>Ida Tartaglia</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16 SOCIAL SECURITY NO. <b>128-09-3227</b>	
17 INFORMANT <b>Amedeo Chiappetta</b>		Address <b>Box 261 Carroll Manor Rd.</b>	
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>CEREBRAL EDEMA</b> DUE TO (b) <b>CARCINOMATOSIS - GENERALIZED</b> DUE TO (c) <b>CARCINOMA (ADENO) OVARIAN</b>			INTERVAL BETWEEN ONSET AND DEATH <b>6 MOS</b> <b>11 MOS</b>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II at item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (1) (this hospital) attended the deceased from <b>Feb</b> , 1967 to <b>Nov</b> , 1967 that (1) (we) last saw the deceased alive on <b>13 Nov 1967</b> , and that death occurred at <b>8:20 PM</b> from causes and on the date stated above.			
22a. SIGNATURE <b>Donald O. Wood</b>		22b. DATES SIGNED <b>11/15/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Donald O. Wood</b>		22d. ADDRESS <b>Timonium MD</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>11/16/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Dulaney Valley Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Cockeysville, Md.</b>
24. FUNERAL DIRECTOR <b>Wm. Cook-Brooks Towson 1050 York Rd, 21204</b>		25a. RECEIVED BY REGISTRAR <b>NOV 20 1967</b>	
		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	



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VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
14912 CERTIFICATE OF DEATH 14917									
1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>BALTO</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TOWSON</u>			c. LENGTH OF STAY IN 1b "		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TOWSON</u>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>GBMC</u>					d. STREET ADDRESS <u>1000 E. JOPPA ROAD 21204</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>BABY</u>		First <u>BABY</u> Middle <u>BOY</u> Last <u>CHOUHARY</u>		4. DATE OF DEATH Month <u>11</u> Day <u>19</u> Year <u>1967</u>					
5. SEX <u>M</u>		6. COLOR OR RACE <u>INDIAN</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11/19/67</u>		9. AGE (In years last birthday) yrs. <u>35</u> Months <u>35</u> Days <u>35</u> Hours <u>35</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NEWBORN</u>			10b. KIND OF BUSINESS OR INDUSTRY "		11. BIRTHPLACE (County & State, or foreign country) <u>BALTIMORE CO. MD.</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>SURESH C. CHOUHARY</u>					14. MOTHER'S MAIDEN NAME <u>INGE THEA LECHNER</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>MOTHER</u>		Address <u>1000 E JOPPA RD 21204</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Immaturity</u> DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>11/19, 1967</u> , to <u>11/19, 1967</u> , that (II) (we) last saw the deceased alive on <u>11/19, 1967</u> , and that death occurred at <u>5 P.M.</u> from the causes and on the date stated above.									
22a. SIGNATURE <u>George H. Davis</u>					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>11/19/67</u>		
22c. PHYSICIAN'S NAME (Type) <u>GEORGE H. DAVIS, M.D.</u>					22d. ADDRESS <u>TIMONIUM, MD. 21093</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		23b. DATE THEREOF <u>11/20/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>GBMC</u>			23d. LOCATION (City, town or county) (State) <u>Towson, Md.</u>		
24. FUNERAL DIRECTOR <u>John E. Adams, M.D.</u>					ADDRESS <u>GBMC</u>		25a. REC'D BY REGISTRAR <u>NOV 22 1967</u>		
					25b. REGISTRAR'S SIGNATURE <u>Thomas Judge</u>				





MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14913

CERTIFICATE OF DEATH

14918

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institutional Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>11</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pikesville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pikesville</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>601 Cliveden Rd</u>		e. STREET ADDRESS <u>601 Cliveden</u>	
3. NAME OF DECEASED (Type or print) <u>John Cameron Christy</u>		4. DATE OF DEATH Month <u>11</u> - Day <u>20</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-14-97</u>
9. AGE (In years, last birthday) <u>76</u> yrs		10. IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>GARAGE OWNER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OTTAWA, CANADA</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>George Christy</u>		14. MOTHER'S MAIDEN NAME <u>HARRIET McVeity</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>218-32-1210</u>	
17. INFORMANT <u>Ada T. Christy</u> Address <u>Same</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I: DEATH WAS CAUSED BY: <u>4201</u> IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> DUE TO (b) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO (c) <u>Carcinoma of Bladder</u>			INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u> <u>years</u> <u>2+ years</u>
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY: Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>7-7-</u> , 19 <u>66</u> , to <u>death</u> , 19 <u>  </u> , that (I) (we) last saw the deceased alive on <u>11-14-67</u> 19 <u>  </u> , and that death occurred at <u>  </u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>John D. Young, Jr.</u> M.D.		22b. DATE SIGNED <u>11-22-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>John D. Young, Jr., M.D.</u>		22d. ADDRESS <u>University Hospital Balto., Md. 21201</u>	
23a. BURIAL, CREMATION, or REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>11-24-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cemetery, Baltimore, Md.</u>	23d. LOCATION (City or Town) (County) (State)
24. FUNERAL DIRECTOR <u>Ellsworth Armacost</u>		25a. REC'D BY REGISTRAR <u>NOV 24 1967</u>	
ADDRESS <u>4600 Liberty Heights Ave</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and in any event, within 2 hours after death should be filed with the State Dept. of Health prior to burial, cremation, or removal.

1.  
681  
728

14916

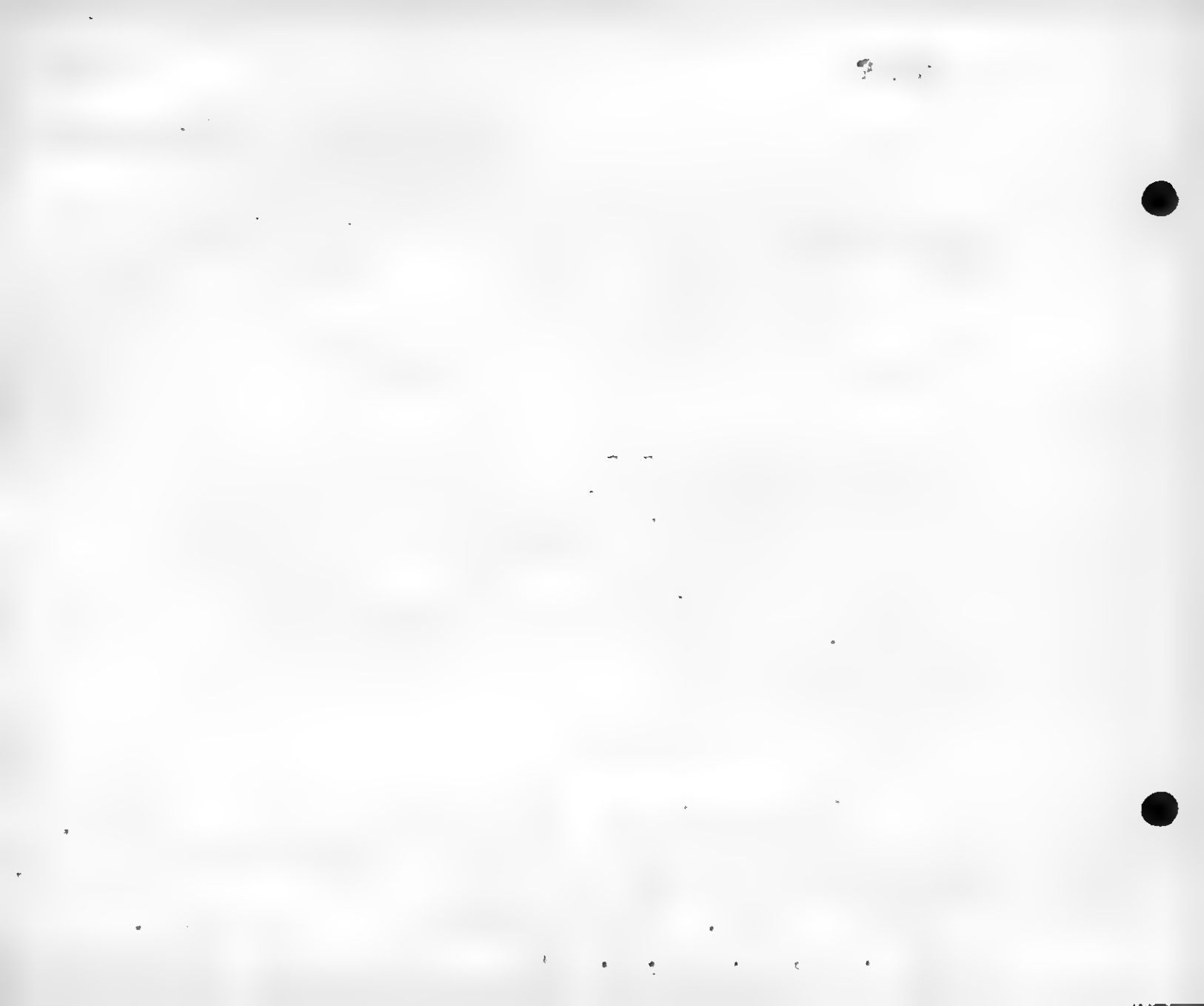
## CERTIFICATE OF DEATH

14919

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institut on Residence before adm ssion) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u>		c. LENGTH OF STAY IN 1b <u>20 days</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>BALTO. CO. GEN. Hosp.</u>		d STREET ADDRESS <u>3613 Keystone Ave.</u>	
3 NAME OF DECEASED (Type or print) First <u>Ethel</u> Middle <u>C</u> Last <u>Clem</u>		4 DATE OF DEATH Month <u>11</u> Day <u>30</u> Year <u>1967</u>	
5 SEX <u>F</u>	6 COLOR OR RACE <u>W</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>12-8-01</u>
9 AGE (In years lost birthday) <u>65</u> yrs.		10 IF UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS <input type="checkbox"/> Months Days Hours Min	
10a USUAL OCCUPATION (Give kind of work done during most of work ng life, even if retired) <u>Housewife</u>		10b KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12 CIT ZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Walter S. Amos</u>		14 MOTHER'S M A DEN NAME <u>Nellie Harrison</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give wor or dates of service) <u>No</u>		16 SOCIAL SECURITY NO. <u>219-16-9730</u>	
17 INFORMANT <u>Hosp. Record</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>401r</u> DUE TO (b) <u>MULTIPLE PULMONARY INFARCTS</u> DUE TO (c) <u>MULTIPLE PERIPHERAL PULMONARY EMBOLI</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost <u>Arteriosclerosis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>DAYS</u> <u>11</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) <u>Thrombosis of left ATRIUM - MITRAL STENOSIS</u>			19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <u>19</u>	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>11-10-1967</u> , to <u>11-30-1967</u> , that (I) (we) last saw the deceased alive on <u>11-30-1967</u> , and that death occurred at <u>3:35A.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Samuel Call, MD</u>		22b. DATE SIGNED <u>11/30/67.</u>	
22c. PHYSICIAN'S NAME (Type)		22d ADDRESS <u>Baltimore County General Hosp.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>12/4/67.</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Md.</u>
24. FUNERAL DIRECTOR <u>Leonard J. Rueck, Inc., Balto, Md. 21214</u>		25a. REC'D BY REGISTRAR <u>DEC 1 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

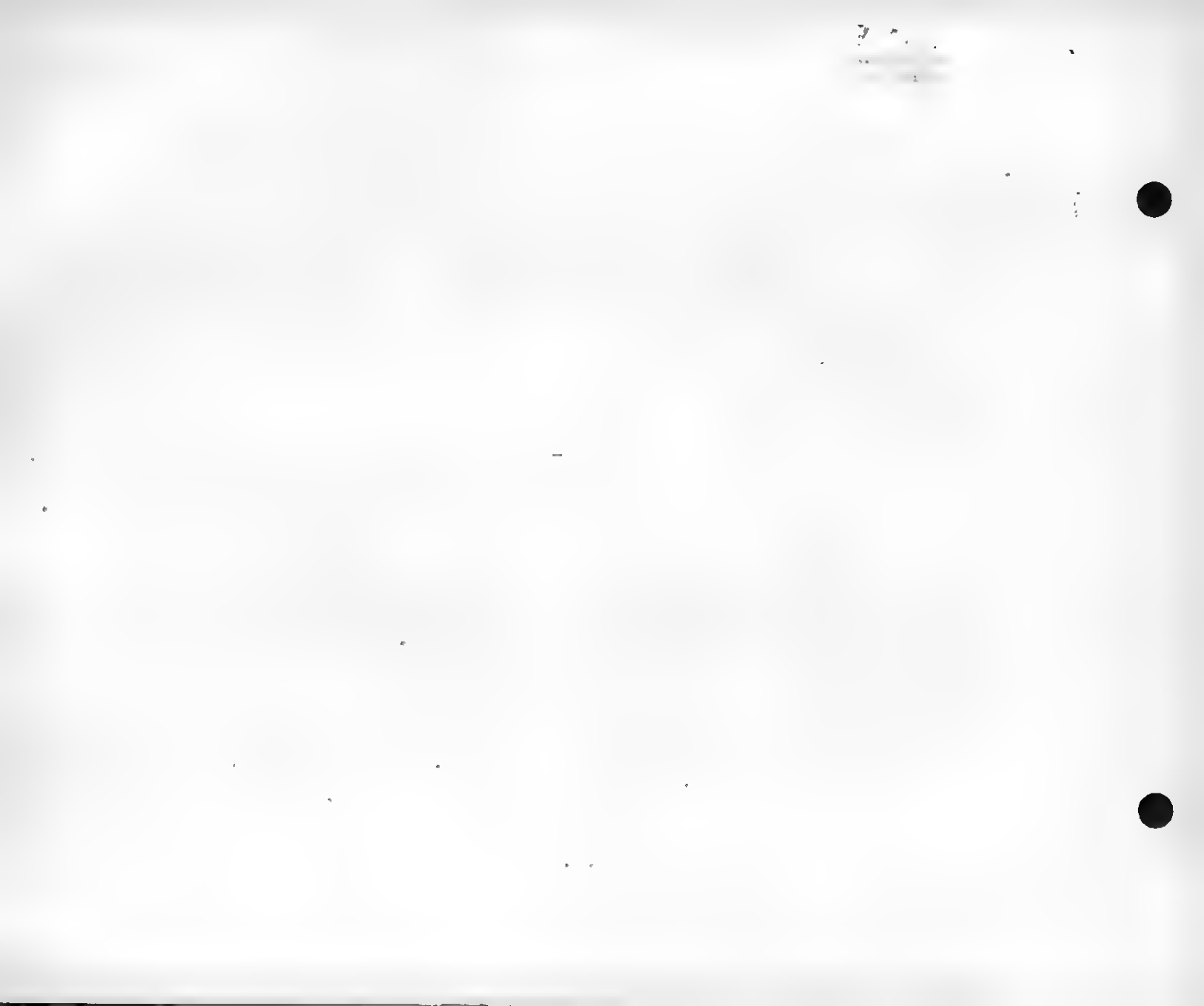
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
Items #23a, c & d Form #1395 11/30/67 ph

14913

CERTIFICATE OF DEATH

14920

1 PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a STATE <b>Maryland</b> b COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN lb <b>34yr8days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>SPRING GROVE STATE HOSPITAL</b>		e. STREET ADDRESS <b>125 Greene Street</b>	
3 NAME OF DECEASED (Type or print) <b>Thelma Grimm Cockey</b>		4 DATE OF DEATH Month <b>November</b> Day <b>3</b> Year <b>1967</b>	
5 SEX <b>female</b>	6 COLOR OR RACE <b>white</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 14, 1899</b>
9 AGE (In years last birthday) <b>68</b> yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12 CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
13 FATHER'S NAME <b>William Grimm</b>		14 MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16 SOCIAL SECURITY NO. <b>219-54-3071T</b>	
17. INFORMANT <b>Records: SPRING GROVE STATE HOSP.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Multiple Myeloma</b> DUE TO (b) <b>lesions</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)		INTERVAL BETWEEN ONSET AND DEATH <b>4 yrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Myeloma Kidney; anemia secondary to Ia.; multiple osteo-</b>		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)		20f (City or town) (County) (State)	
21. I certify that (this hospital) attended the deceased from <b>Oct. 25, 1933</b> to <b>Nov. 3, 1967</b> , that (we) last saw the deceased alive on <b>Nov. 3, 1967</b> , and that death occurred at <b>4:30</b> M, from causes and on the date stated above.			
22a SIGNATURE <b>Anthony J. Young, M.D.</b>		22b DATE SIGNED <b>11-3-67</b>	
22c PHYSICIAN'S NAME (Type) <b>Anthony J. Young, M.D.</b>		22d ADDRESS <b>SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b DATE THEREOF	
23c NAME OF CEMETERY OR CREMATORY <b>Anatomy Board of Md.</b>		23d LOCATION (City or Town) (County) (State)	
24 FUNERAL DIRECTOR <b>Newell Funeral Home</b>		25a REC'D BY REGISTRAR <b>NOV 8 1967</b>	
25b REGISTRAR'S SIGNATURE <b>William J. Young</b>			



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14916

CERTIFICATE OF DEATH

14921

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1 PLACE OF DEATH a COUNTY <b>BALTIMORE</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE <b>MARYLAND</b> b COUNTY <b>BALTIMORE</b>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RANDALLSTOWN</b>		c LENGTH OF STAY IN 1b <b>RANDALLSTOWN</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>3805 PIKESWOOD DRIVE</b>		d STREET ADDRESS <b>3805 PIKESWOOD DRIVE</b>	
3. NAME OF DECEASED (Type or print) First <b>REBA</b> Middle <b>COHEN</b> Last <b>COHEN</b>		4 DATE OF DEATH Month <b>NOVEMBER</b> Day <b>6</b> Year <b>1967</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>MARCH 26, 1900</b>
9 AGE (In years last birthday) <b>67 yrs</b>		IF UNDER 1 YEAR Months <b>6</b> Days <b>19</b> Hours <b>67</b> Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>AT HOME</b>	
11 BIRTHPLACE (County & State or foreign country) <b>BALTIMORE, MARYLAND</b>		12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>HYMAN FARBEN</b>		14. MOTHER'S MAIDEN NAME <b>YETTA ?</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>MRS. JANICE BAUMEL, 3805 PIKESWOOD DRIVE, RANDALLSTOWN, MD. 21133</b>		18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Carcinoma of Breast</b> 170X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Hypertensive (arteriosclerotic) Cardiovascular Disease</b> DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>CHF</b>		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>July, 1967</b> to <b>11/6, 1967</b> , that (I) (we) last saw the deceased alive on <b>11/6, 1967</b> , and that death occurred at <b>8:30 M.</b> from causes and on the date stated above.			
22a. SIGNATURE <b>Dr. Marvin Siontz</b>		22b DATE SIGNED <b>11/6/67</b>	
22c PHYSICIAN'S NAME (Type) <b>DR. MARVIN SAIONTZ</b>		22d ADDRESS <b>4000 W. NORTHERN PKWY.</b>	
23a BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b DATE THEREOF <b>11-8-67</b>	23c NAME OF CEMETERY OR CREMATORY <b>SHAAREI ZION</b>	23d LOCATION (City or town) (County) (State) <b>BALTIMORE, MARYLAND</b>
24. FUNERAL DIRECTOR <b>SOL LEVINSON &amp; BROS. INC., 6010 REISTERSTOWN RD.</b>		25a REC'D BY REGISTRAR <b>NOV 9 1967</b>	25b REGISTRAR'S SIGNATURE <b>Charles Judge</b>





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

148-295

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14917

CERTIFICATE OF DEATH

14022

1 PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>TOWSON</b>		c. LENGTH OF STAY IN IS <b>7 days</b>		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>REISTERSTOWN</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>ST. JOSEPH HOSPITAL</b>				e. STREET ADDRESS <b>405 SACRED HEART LANE #21136</b>	
3 NAME OF DECEASED (Type or print) First Middle Last <b>JANE MARIE CONNOLLY</b>			4. DATE OF DEATH Month Day Year <b>NOVEMBER 26 19 67</b>		
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>NOVEMBER 19, 1967</b>		9 AGE (In years last birthday) yrs <b>7</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>INFANT</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>---</b>		11 BIRTHPLACE (County & State or foreign country) <b>Baltimore, Maryland</b>	
13 FATHER'S NAME <b>WALTER WILLIAM CONNOLLY</b>			14 MOTHER'S MAIDEN NAME <b>KATHLEEN ANN CARNEY</b>		
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16 SOCIAL SECURITY NO. <b>none</b>		17 INFORMANT <b>Mr. Walter W. Connolly, 405 Sacred Heart Reisterstown, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Immaturity</b> DUE TO <b>776X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____					INTERVA. BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc)	20f (City or town)	(County)	(State)
21. I certify that (I) (this hospital) attended the deceased from <b>NOVEMBER 19, 19 67</b> , to <b>NOVEMBER 26 19 67</b> that (I) (we) last saw the deceased alive on <b>NOVEMBER 26 19 67</b> , and that death occurred at <b>2:05 AM</b> , from causes on and on the date stated above					
22a. SIGNATURE <i>Jose A. Aguto</i>			M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>11-26-67</b>
22c. PHYSICIAN'S NAME (Type) <b>Jose A. Aguto, M.D.</b>			22d. ADDRESS <b>7620 York Road, Towson, Md. 21204</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)		
<b>Burial</b>	<b>11/27/67</b>	<b>Woodlawn Cemetery</b>	<b>Woodlawn, Balto. Co., Md.</b>		
24 FUNERAL DIRECTOR <i>4 J. Edwards</i>			ADDRESS <b>Owings Mills, Md.</b>		25a REC'D BY REGISTRAR DATE <b>NOV 28 1967</b>
			25b REGISTRAR'S SIGNATURE <i>Charles Judge</i>		

1744



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1

MARYLAND STATE DEPARTMENT OF HEALTH

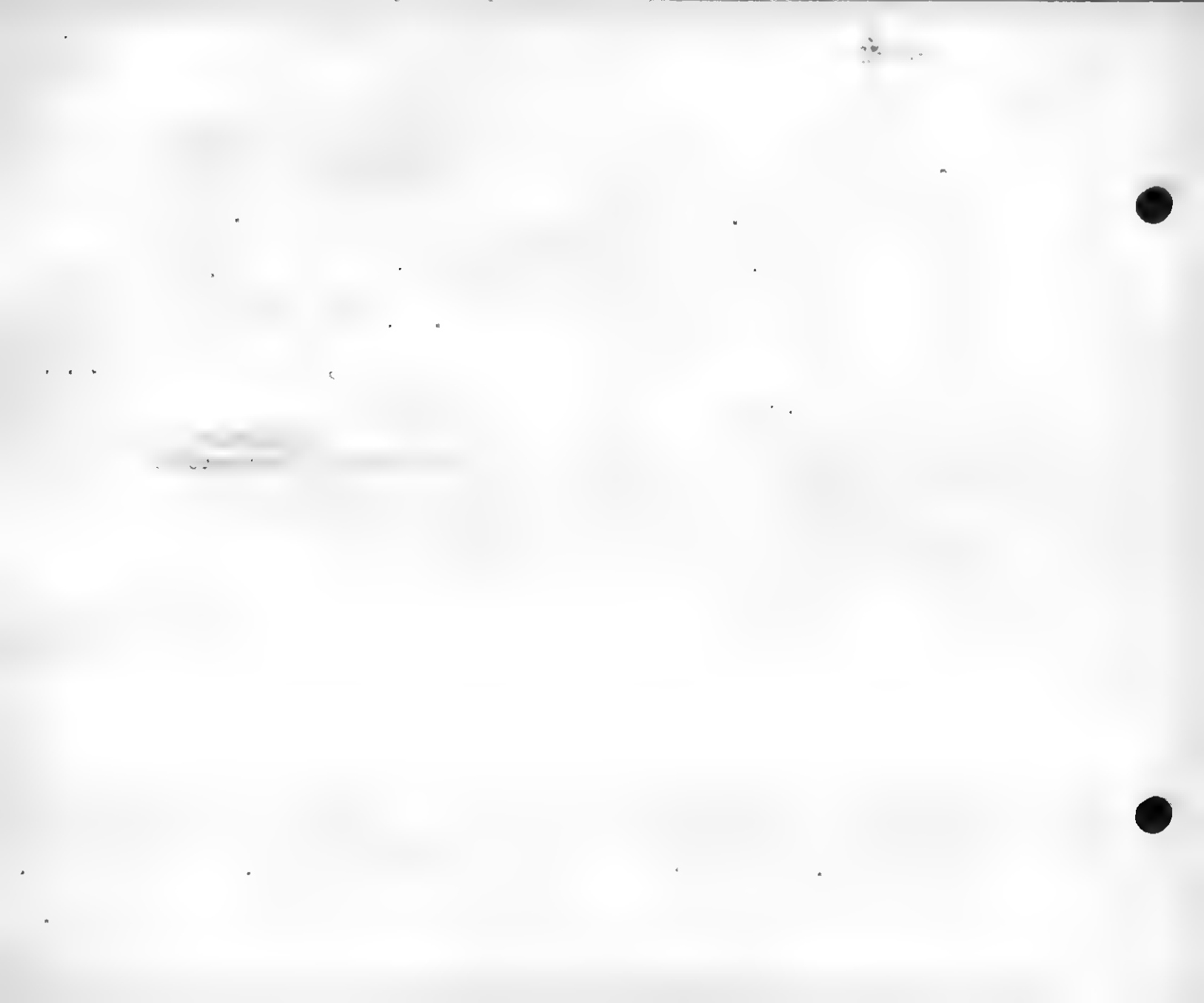
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14918

CERTIFICATE OF DEATH

14023

1 PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Randallstown</b> c. LENGTH OF STAY IN TB <b>21133</b>		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Randallstown</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>8611 Allenswood Rd. 21133</b>		d. STREET ADDRESS <b>8611 Allenswood Rd.</b>	
3 NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>Lyda</b> Last <b>Connolly</b>		4. DATE OF DEATH Month <b>Nov.</b> Day <b>10</b> Year <b>19 67</b>	
5 SEX <b>Female</b>	6 COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>Sept. 25, 1892</b>
9 AGE (In years last birthday) <b>75</b>		IF UNDER 1 YEAR Months <b>7</b> Days <b>7</b> Hours <b>7</b> Min <b>7</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>none</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore, Md</b>		12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>James Mc Carrier</b>		14. MOTHER'S MAIDEN NAME <b>Mary Combs</b>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16 SOCIAL SECURITY NO. <b>none</b>	
17 INFORMANT <b>Mr Ivy Connolly</b>		18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) <b>Old CVA. (2 yrs)</b>	
19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <b>5 yrs</b>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 8)	
20c TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> pm <b>19</b>		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that (1) (this hospital) attended the deceased from <b>11/10</b> , 19 <b>60</b> , to <b>11/10</b> , 19 <b>67</b> that (1) (we) last saw the deceased alive on <b>11/10</b> , 19 <b>67</b> , and that death occurred at <b>8 A.M.</b> from causes and on the date stated above			
22a. SIGNATURE <b>Dr. Morton Ellin</b>		22b. DATE SIGNED <b>11/11/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. Morton Ellin</b>		22d. ADDRESS <b>8629 Liberty Rd. Randallstown, Md.</b>	
23a BURIAL, CREMATION, or other disposition <b>Burial</b>		23b DATE THEREOF <b>11/14/67</b>	
23c NAME OF CEMETERY OR CREMATORY <b>Greenmount Cemetery</b>		23d LOCATION (City or Town) (County) (State) <b>Baltimore Md.</b>	
24 FUNERAL DIRECTOR <b>Foring Byers</b>		25a RECEIVED BY REGISTRAR <b>NOV 14 1967</b>	
25b REGISTRAR'S SIGNATURE <b>Charles Judge</b>		25c ADDRESS <b>8728 Liberty Rd. Randallstown, Md.</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
14912					14924				
1 PLACE OF DEATH					2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)				
a. COUNTY <i>Baltimore</i> MARYLAND					a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Catonsville</i>				c. LENGTH OF STAY IN TB	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Sunmit Nursing Home</i>					d. STREET ADDRESS <i>425 S. Gilman St</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3 NAME OF DECEASED (Type or print)					4. DATE OF DEATH				
First <i>James</i> Middle <i>W.</i> Last <i>Cooper, Sr</i>					Month <i>Nov.</i> Day <i>21</i> Year <i>19 67</i>				
5 SEX <i>Male</i>	6 COLOR OR RACE <i>Wh</i>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8 WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <i>July 6 1891</i>		9 AGE (In years last birthday) yrs. <i>76</i>	10 IF UNDER 1 YEAR Months	11 IF UNDER 24 HRS. Days	12 Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Print Press</i>			10b. KIND OF BUSINESS OR INDUSTRY <i>Machinery</i>		11 BIRTHPLACE (County & State, or foreign country) <i>Virginia</i>			12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>Charles Cooper</i>					14 MOTHER'S MAIDEN NAME				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			16 SOCIAL SECURITY NO <i>215 22 8035 A</i>		17 INFORMANT Address <i>Mrs. Katherine Cooper, 425 S Gilman St</i>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>4231 Arteriosclerotic cardiac base disease.</i> DUE TO (b) <i>Generalized arterioscl.</i> DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Diabetes Mellitus</i>								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>19</i> p.m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <i>9:20</i> to <i>9:21</i> , 19 <i>67</i> , that (I) (we) last saw the deceased alive on <i>9-20</i> 19 <i>67</i> and that death occurred at <i>9:21</i> M, from causes and on the date stated above.									
22a. SIGNATURE <i>Joshua Kudirka</i>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED		
22c. PHYSICIAN'S NAME (Type) <i>J. KUDIRKA</i>					22d. ADDRESS <i>2151 Wilkes Ave</i>				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or town) (County) (State)		
<i>Burial</i>		<i>11-25-67</i>		<i>Loudon Park Cemetery</i>			<i>Balto Md</i>		
24. FUNERAL DIRECTOR <i>Thomas J. Kenny Inc 1600 Hollins Balto Md 23</i>					25a. REC'D BY REGISTRAR DATE <i>NOV 22 1967</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14920

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14-25

1 PLACE OF DEATH a. COUNTY <u>Balti.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution on Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balti.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Balti.</u> 15		c. LENGTH OF STAY N. 1b <u>3 yrs.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>6700 Nutt Avenue Ave.</u>		d. STREET ADDRESS <u>Balti.</u>	
3 NAME OF DECEASED (Type or print) First Middle Last <u>JOSEPH BENJAMIN COOPER</u>		4 DATE OF DEATH Month Day Year <u>Nov 17 1967</u>	
5 SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>2-17-44</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>Salesman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Life Ins.</u>	9 AGE (in years lost birthday) yrs. <u>23</u>
11 BIRTHPLACE (State or foreign country) <u>Md.</u>		12 CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph J. Cooper</u>		14. MOTHER'S MAIDEN NAME <u>Elsie Long</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>yes World War II</u>		16 SOCIAL SECURITY NO <u>217-01-8200</u>	
17 INFORMANT <u>Marguerite E. Reese</u>		Address <u>4028 Philadelphia Rd. Balt. 5</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO <u>arteriosclerotic C.V. disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Diabetes</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs.</u> <u>25 yrs.</u>
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>none.</u>			9 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <u>None</u>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>None</u>	
20c. TIME OF INJURY Month Day Year Hour o'm p.m. <u>None 19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work <u>None</u>	20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.) <u>None</u>
20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspect an <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion on death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>D.D. Caples</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>D.D. CAPLES</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		Address (Street, city, town or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>11-20-67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Cathedral Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Balti. Md.</u>	
24 FUNERAL DIRECTOR <u>Loring Byers</u>		ADDRESS <u>8728 Liberty Road</u>	
25a. RECD BY REGISTRAR DATE <u>NOV 20 1967</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

14921

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

14926

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rural Towson</u> c. LENGTH OF STAY IN b <u>8 1/2 hrs.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Greater Baltimore Medical Center</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Towson</u> d. STREET ADDRESS <u>8217 B. Loch Raven Blvd.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First <u>Baby</u> Middle <u>boy</u> Last <u>Corbett</u>		4. DATE OF DEATH Month <u>Nov.</u> Day <u>22</u> Year <u>1967</u>		5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11/22/67</u>		9. AGE (In years last birthday) <u>8</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>8</u> Days <u>39</u> Hours <u>39</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>—</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>				11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore County, Md.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Thomas Reed Corbett</u>						14. MOTHER'S MAIDEN NAME <u>Elizabeth Weatherman</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>—</u>				17. INFORMANT Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory &amp; cardiac arrest</u> DUE TO (b) <u>Respiratory distress syndrome</u> DUE TO (c) <u>Immaturity and prematurity</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)												INTERVAL BETWEEN ONSET AND DEATH <u>7 hrs</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>													
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>355 AM</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Nov 22, 1967</u> , to <u>Nov 22, 1967</u> , that (I) (we) last saw the deceased alive on <u>Nov 22, 1967</u> , and that death occurred at <u>11:29 PM</u> , from the causes and on the date stated above.													
22a. SIGNATURE <u>Jere P. Smith</u>												22b. DATE SIGNED <u>11/22/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Jere P. Smith</u>												22d. ADDRESS <u>Greater Baltimore Medical Center</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE THEREOF				23c. NAME OF CEMETERY OR CREMATORY <u>GBMC</u>				23d. LOCATION (City, town or county) (State)	
24. FUNERAL DIRECTOR <u>R. Bartinecker</u> ADDRESS <u>GBMC</u>													
25a. REC'D BY REGISTRAR <u>DEC 4 1967</u>												25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

MEDICAL CERTIFICATION



# FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
GM 1/67

14922

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

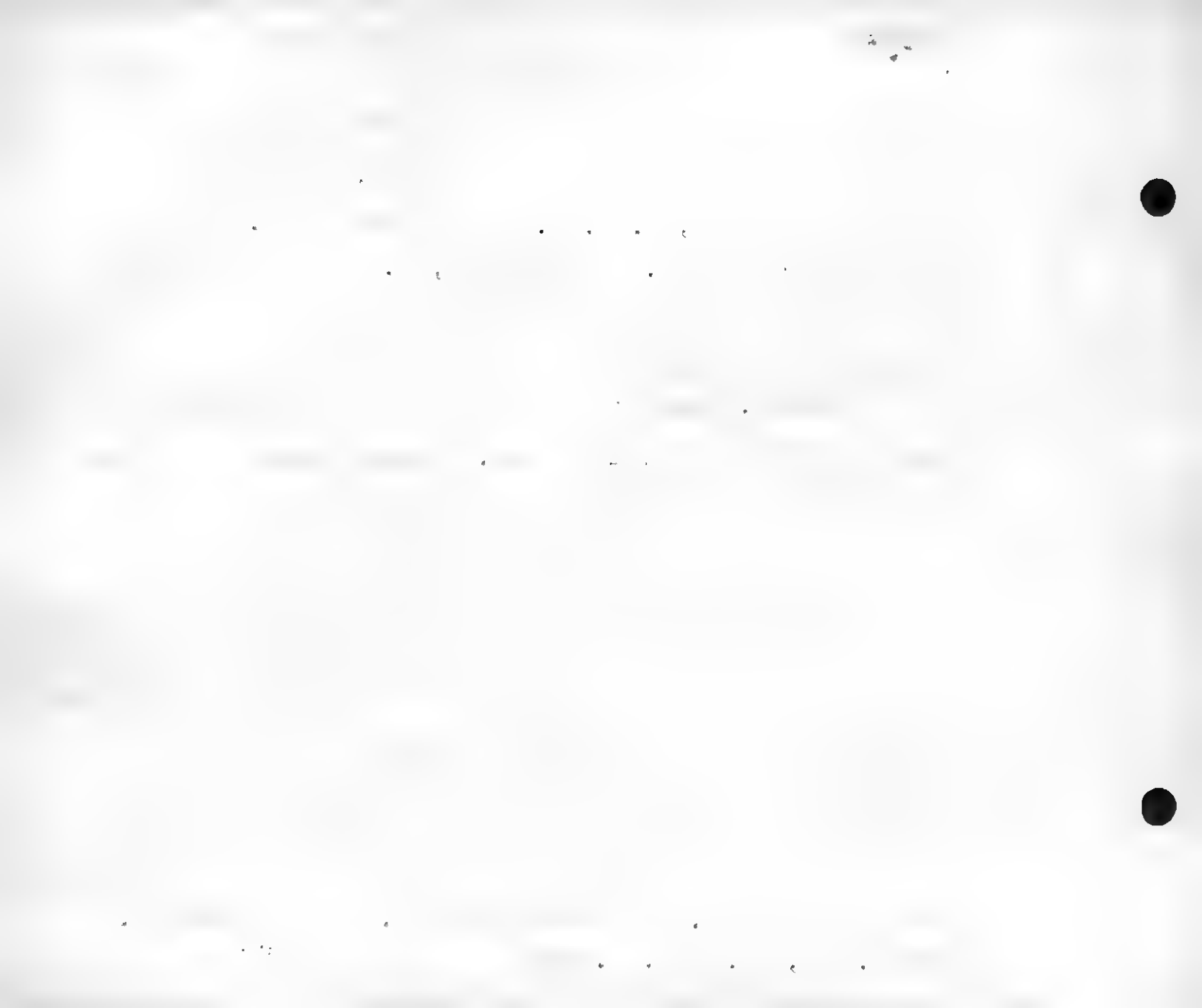
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14927

1 PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Bethlehem Steel Hospital, Sp. Pt. Md.</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore, Maryland</b>	
3 NAME OF DECEASED (Type or print) <b>William H. Cornbrooks, Sr.</b>		4 DATE OF DEATH Month <b>11</b> Day <b>15</b> Year <b>19 67</b>	
5 SEX <b>Male</b>	6 COLOR OR RACE <b>Cau</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>2-18-08</b>
9 AGE (in years last birthday) <b>59</b> yrs		10 IF UNDER 1 YEAR Months <b>11</b> Days <b>15</b> Hours <b>19</b> Min <b>67</b>	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Draftsman</b>		10b KIND OF BUSINESS OR INDUSTRY <b>Shipbuilding</b>	
11 BIRTHPLACE (State or foreign country) <b>Maryland</b>		12 CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13 FATHER'S NAME <b>Thomas M. Cornbrooks</b>		14. MOTHER'S MAIDEN NAME <b>Harriett Walters</b>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16 SOCIAL SECURITY NO <b>151-01-3290</b>	
17 INFORMANT <b>Mrs. Elizabeth Cornbrooks</b>		Address <b>(Same)</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Acute Coronary Occlusion</b> DUE TO <b>Arteriosclerotic Heart Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>15-20 m</b> (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I, (a)			
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Theo C. Patterson</b> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>THEO. C. PATTERSON</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		Address (Street, city, town, or county)	
23a BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b DATE THEREOF <b>11/18/67.</b>	23c NAME OF CEMETERY OR CREMATORY <b>Moreland Memorial Cem.</b>	23d LOCAT ON (City or town) (County) (State) <b>Baltimore, Md.</b>
24 FUNERAL DIRECTOR <b>Leonard J. Ruck, Inc. Balto. Md. 21214</b>		25a REC'D BY REGISTRAR <b>NOV 16 1967</b>	
		25b REGISTRAR'S SIGNATURE <b>W. H. ...</b>	

22. DATE SIGNED

**11/15/67**



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14922

## CERTIFICATE OF DEATH

14928

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> c. LENGTH OF STAY IN 1b <u>5-6 yrs</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Caton Ridge Nursing Home</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Taken Burial</u> d. STREET ADDRESS <u>52nd Ave</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Archie W. Coulter</u> First Middle Last				4. DATE OF DEATH <u>11/24/67</u> Month Day Year			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7/13/07</u> yrs. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unknown</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Unknown</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Wash. D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Alfred Coulter</u>				14. MOTHER'S MAIDEN NAME <u>Kinchloe</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>577-26-0531</u>		17. INFORMANT <u>Hosp. Chart</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular Thrombosis</u> DUE TO (b) <u>Arteriosclerosis</u> DUE TO (c) <u>Unknown</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH <u>1 Day</u> <u>20 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>9/13</u> , 19 <u>67</u> , to <u>11/24</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>11/24</u> , 19 <u>67</u> and that death occurred at <u>2:00</u> AM, from the causes and on the date stated above.							
22a. SIGNATURE <u>David E. Zickler</u> M.D.				22b. DATE SIGNED <u>11/25/67</u>			
22c. PHYSICIAN'S NAME (Type) <u>David E. Zickler, M.D.</u>				22d. ADDRESS <u>AVENUE W. Hillcrest City, MD.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>11/27/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Hillcrest Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Annapolis A.A. Md.</u>	
24. FUNERAL DIRECTOR <u>Beverly E. Hopping</u> Hopping Funeral Home - Annapolis, Md.				25a. REC'D BY REGISTRAR <u>NOV 29 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



14924

CERTIFICATE OF DEATH

14929

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George'</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Takoma Park, Maryland</b>	
c. LENGTH OF STAY IN 1b <b>4yr7mth26dys</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>SPRING GROVE STATE HOSPITAL</b>		d. STREET ADDRESS <b>1207 Elson Place</b>	
3 NAME OF DECEASED (Type or print) <b>Ophelia Tabitha Courtney</b>		4 DATE OF DEATH <b>November 27 19 67</b>	
5 SEX <b>female</b>	6 COLOR OR RACE <b>white</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>Oct. 21, 1874</b>
9 AGE (In years lost birthday) <b>93 yrs</b>		F UNDER 1 YEAR Months Days HOURS Min. <b>12</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Virginia U.S. of A.</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S. of A.</b>	
13. FATHER'S NAME <b>Albert Lewis Courtney</b>		14. MOTHER'S MAIDEN NAME <b>Laura Dennis</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO <b>220-54-1232</b>	
17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY. <b>491X Pneumonia, bilateral, bronchial, org.unk. 4 days</b> IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Anterior sclerotic Corneal vascular Mt. Dis. with previous Inf.</b>			
19 WAS AUTOPSY PERFORMED? <b>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)		20f. (City or town) (County) (State)	
21. I certify that (if this hospital) attended the deceased from <b>March 31, 19 67</b> to <b>Nov. 27, 1967</b> , that (if) (we) last saw the deceased alive on <b>Nov. 27 1967</b> , and that death occurred at <b>11:40</b> M, from causes and on the date stated above			
22a. SIGNATURE <b>Anthony J. Young, M.D.</b>		22b. DATE SIGNED <b>11-27-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Anthony J. Young, M.D.</b>		22d. ADDRESS <b>SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11/30/1967</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Prospect Hill</b>		23d. LOCATION (City or Town) (County) (State) <b>Washington, D. C.</b>	
24. FUNERAL DIRECTOR <b>Arthur Walters</b>		25a. REC'D BY REGISTRAR <b>254 Carroll St. N.W. Washington, D.C. 20012</b>	
25b. REGISTRAR'S SIGNATURE <b>NOV 30 1967</b>			





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MEDICAL CERTIFICATION

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
14325													
CERTIFICATE OF DEATH													
1. PLACE OF DEATH a. COUNTY <u>Balto.</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Greater Balto. med. center.</u>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>1</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u> d. STREET ADDRESS <u>1014 York Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>James.</u> Middle <u>Malin</u> Last <u>Cousins</u>			4. DATE OF DEATH Month <u>11</u> Day <u>4</u> Year <u>1967</u>			5. SEX <u>m</u>			6. COLOR OR RACE <u>Cauc</u>				
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <u>8-31-91</u>			9. AGE (In years last birthday) <u>76</u> yrs.			IF UNDER 1 YEAR Months Days Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired</u>			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country) <u>Balto. Md.</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>				
13. FATHER'S NAME <u>James M. Cousins.</u>						14. MOTHER'S MAIDEN NAME <u>Devaney.</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>UNK</u>			16. SOCIAL SECURITY NO. <u>214-12-4171</u>			17. INFORMANT <u>chart.</u>			Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Massive intracerebral bleeding + aspiration</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Erasing of tumor in vessel</u> DUE TO (c) <u>Widespread carcinoma of lung</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)												INTERVAL BETWEEN ONSET AND DEATH <u>Nov 4/1967</u> <u>1966</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)										
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <u>11/3</u> , 19 <u>67</u> , to <u>11/4</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>11/4</u> , 19 <u>67</u> , and that death occurred at <u>10 P.M.</u> from the causes and on the date stated above.													
22a. SIGNATURE <u>M. Estelle Connolly</u>						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22b. DATE SIGNED <u>11/4/67</u>				
22c. PHYSICIAN'S NAME (Type) <u>M. Estelle Connolly</u>						22d. ADDRESS <u>G.B.M.C.</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>			23b. DATE THEREOF <u>Nov. 7, 1967</u>			23c. NAME OF CEMETERY OR CREMATORY <u>Eastern Cemetery</u>			23d. LOCATION (City, town or county) (State) <u>Baltimore, Maryland</u>				
24. FUNERAL DIRECTOR <u>John J. Burns Sons</u>			ADDRESS <u>1000 N. ...</u>			25a. REC'D BY REGISTRAR <u>NOV 7 1967</u>			25b. REGISTRAR'S SIGNATURE <u>R. Charles Judge</u>				



14926

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14931

FOR STATE  
HEALTH DEPT.

This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) <b>Timonium</b> c. LENGTH OF STAY IN 1b <b>Timonium</b>		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Timonium</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>7 Washington Street</b>		d. STREET ADDRESS <b>7 Washington St.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last <b>LAWRENCE PATRICK CAVAHEY</b>		4 DATE OF DEATH Month Day Year <b>November 2, 1967</b>	
5 SEX <b>Male</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>May 19, 1908</b>
9 AGE (In years last birthday) <b>59 yrs</b>		10 UNDER 1 YEAR Months Days Hours Min <b>59</b>	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Inspector</b>		10b KIND OF BUSINESS OR INDUSTRY <b>Baltimore</b>	
11 BIRTHPLACE (State or foreign country) <b>Maryland</b>		12 CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13 FATHER'S NAME <b>Thomas J. Cavahey</b>		14 MOTHER'S MAIDEN NAME <b>Mary C. Brady</b>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>yes 11</b>		16 SOCIAL SECURITY NO <b>219-16-3953</b>	
17 INFORMANT <b>Family records</b>		Address	
18 CAUSE OF DEATH (Enter on only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Shotgun Wound of Abdomen</b> 716A DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTE TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)			INTERVAL BETWEEN ONSET AND DEATH
20a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <b>Shot self in abdomen</b>	
20c TIME OF INJURY Month Day Year Hour am pm <b>UNK pm 11/2 1967</b>		20d INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) <b>Home</b>		20f (City or town) (County) (State) <b>Baltimore, Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Werner U. Spitz, M.D.</b>		22. DATE SIGNED <b>11/3/67</b>	
EXAMINER'S NAME (Type) <b>Werner U. Spitz, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county)	
23a BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	23b DATE THEREOF <b>Nov. 6, 1967</b>	23c NAME OF CEMETERY OR CREMATORY <b>St. Joseph's Cemetery</b>	23d LOCATION (City or Town) (County) (State) <b>Texas, Baltimore Co., Md.</b>
24 FUNERAL DIRECTOR <b>John Burns' Sons, Towson, Maryland</b>		25a REC'D BY REGISTRAR <b>NOV 7 1967</b>	
25b REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



14927

CERTIFICATE OF DEATH

14932

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000.

1 PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institut an Residence before admssion) a. STATE <b>Baltimore</b> MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospita, give street address) <b>St. Joseph Hospital, Towson, Md. 21204</b>		d. STREET ADDRESS <b>1423 Hadwick Drive</b>	
3 NAME OF DECEASED (Type or print) <b>KATHERINE CROUTHAMEL</b>		4 DATE OF DEATH Month <b>November</b> Day <b>24</b> Year <b>19 67</b>	
5 SEX <b>Female</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9-11-20</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore, Md.</b>
13. FATHER'S NAME <b>Archebald McAllister</b>		14. MOTHER'S MAIDEN NAME <b>Mollie V. Keller</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO <b>219-10-0047</b>	17. INFORMANT <b>Raymond Crouthamel</b> Address <b>Essex, Md.</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Massive hemorrhage</b> DUE TO <b>Hepatic decompensation</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>Nutritional cirrhosis</b> (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port I or Port II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <b>24</b> (this hospital) attended the deceased from <b>11-23</b> , <b>1967</b> to <b>11-24</b> , <b>1967</b> , that <b>24</b> (we) last saw the deceased alive on <b>11-24</b> , <b>1967</b> , and that death occurred at <b>4:30P</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>Samuel C. H. Lee, M. D.</b>		22b. DATE SIGNED <b>November 25, 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>Samuel C. H. Lee, M. D.</b>		22d. ADDRESS <b>7620 York Road, Towson 4, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>Nov. 28, 1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Balto. National Cem</b>	23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Maryland</b>
24. FUNERAL DIRECTOR <b>Walters Funeral Home Pratt&amp;stricker Sts.</b>		25a. REC'D BY REGISTRAR <b>NOV 28 1967</b>	
		25b. REGISTRAR'S SIGNATURE <b>Walters</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (1)  
20 AM 1/66

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14922

CERTIFICATE OF DEATH

14933

1 PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>TOWSON</b> c. LENGTH OF STAY IN 1b <b>5 Days</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>ST. JOSEPH HOSPITAL</b>		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>DUNDALK</b> d. STREET ADDRESS <b>6812 BELCLARE RD. #21222</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last <b>CHESTER S. GWYNAR</b>		4 DATE OF DEATH Month Day Year <b>NOVEMBER 20 19 67</b>	
5 SEX <b>MALE</b>	6 COLOR OR RACE <b>WHITE</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>AUGUST 11, 1913</b>
9. AGE (In years lost birthday) <b>54 yrs</b>		10. IF UNDER 1 YEAR Months Days Hours Min <b>19 67</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Welder</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>BETHLEHEM STEEL CO. CLEVELAND, OHIO</b>	
11 BIRTHPLACE (County & State, or foreign country) <b>U.S.A.</b>		12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Stanley Gwynar</b>		14. MOTHER'S MAIDEN NAME <b>Mary ??</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes WWII</b>		16 SOCIAL SECURITY NO. <b>278-07-5995</b>	
17 INFORMANT (Wife) <b>Mrs. Lillian Gwynar, 6812 Belclare Rd.</b>		Address <b>Dundalk, Md.</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Thrombosis of left coronary artery</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>coronary arteriosclerosis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>NOVEMBER 15, 1967</b> , to <b>NOVEMBER 20, 1967</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>NOVEMBER 20, 1967</b> , and that death occurred at <b>2:30 AM</b> from causes and on the date stated above.			
22a SIGNATURE <i>Lillian</i>		22b DATE SIGNED M.D. ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/> <b>11/20/67</b>	
22c PHYSICIAN NAME (Type) <b>Ines Cilliani, M.D.</b>		22d ADDRESS <b>7620 York Rd., Towson, Md. 21204</b>	
23a BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b DATE THEREOF <b>11/24/67</b>	23c NAME OF CEMETERY OR CREMATORY <b>St. Stanislaus Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Md.</b>
24. FUNERAL DIRECTOR <b>John J. Duda, 7922 Wise Ave. Dundalk, Md.</b>		25a REC'D BY REGISTRAR DATE <b>NOV 22 1967</b>	
		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	





CERTIFICATE OF DEATH

14923

14924

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b> c. LENGTH OF STAY IN b. <b>MARYLAND</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Summit Nursing Home</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>3631 Lochearn Drive</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>May Pritchett</b> First <b>May</b> Middle <b>Pritchett</b> Last <b>Day</b>		4. DATE OF DEATH Month <b>Nov.</b> Day <b>4,</b> Year <b>1967</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 26, 1888</b>
9. AGE (In years last birthday) <b>79</b> yrs.		10. IF UNDER 1 YEAR Months <b>7</b> Days <b>9</b> Hours <b>15</b> Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		11b. KIND OF BUSINESS OR INDUSTRY <b>Dorchester Co., Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		13. FATHER'S NAME <b>William G. Day</b>	
14. MOTHER'S MAIDEN NAME <b>Sarah Elizabeth Jones</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	
16. SOCIAL SECURITY NO. <b>215-54-2867</b>		17. INFORMANT <b>Mr. William P. Hughlett</b> Address <b>17 E. Eager St.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ARTERIOSCLECTIC CARDIOMYOSIS</b> DUE TO <b>CUTTER DISEASE</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>SYRST</b> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18)	
21a. TIME OF INJURY Hour <b>a.m.</b> Month, Day, Year <b>19</b>	21b. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	21d. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>1943</b> to <b>11/14</b> , 19 <b>67</b> that (I) (we) last saw the deceased alive on <b>11/13</b> , 19 <b>67</b> , and that death occurred at <b>8:30</b> A.M. from the causes and on the date stated above.			
22a. SIGNATURE <b>Phoebe B. Conrad</b>		22b. DATE SIGNED <b>11/6/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Thos. E. Roach</b>		22d. ADDRESS <b>5550 B&amp;T ROAD PINE B&amp;T 28 MD</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>11/7/1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Lorraine Park Cemetery</b>	23d. LOCATION (City, town or county) (State) <b>Woodlawn, Md.</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. F. Tichner - Sons</b> Address <b>Baltimore, Md.</b>		25a. REC'D BY REGISTRAR <b>NOV 8 1967</b> 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. Page 2 may be retained by the funeral director. After this certificate has been signed by the attending physician and completed, it should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1-2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS-1. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

14930

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14935

1 PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>DUNDALK</b>		c. LENGTH OF STAY in lb <b>DUNDALK 21222</b>	
d. NAME OF HOSPITAL, OR INSTITUTION (If not in hospital, give street address) <b>535 BAYSIDE DRIVE</b>		d. STREET ADDRESS <b>535 BAYSIDE DRIVE</b>	
3 NAME OF DECEASED (Type or print) First <b>EDITH</b> Middle <b>MAY</b> Last <b>DE YORE</b>		4 DATE OF DEATH Month <b>11</b> Day <b>23</b> Year <b>1967</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3-15-1916</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CLERK</b>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <b>51</b> yrs
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>	
13. FATHER'S NAME <b>ARTHUR R. JAMISON</b>		14. MOTHER'S MAIDEN NAME <b>MAY BELL CHASE</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO <b>218-14-5517</b>	
17. INFORMANT <b>MR LESTER L. DE YORE, 535 BAYSIDE DR.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>H-S-C-V-DISEASE</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <b>NO INJURY</b>	
20c. TIME OF INJURY Month Day Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>M. B. Davis</b> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>MELVIN B. DAVIS, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>11-27-67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>HOLY ROSARY CH.</b>		23d. LOCATION (City or Town) (County) (State) <b>BALTO MD.</b>	
24. FUNERAL DIRECTOR <b>Spencer Taylor - 2334 Poppleton St.</b>		25a. REC'D BY REGISTRAR <b>NOV 27 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>James Judge</b>		22. DATE SIGNED <b>11/25/67</b>	



## CERTIFICATE OF DEATH

14931

14936

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1. PLACE OF DEATH a COUNTY <u>BALTIMORE</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE <u>M.D.</u> b COUNTY <u>--</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TOWSON</u>		c LENGTH OF STAY in 1b <u>3018 E BALTO. ST.</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>DULANEY TOWSON NURSING HOME</u>		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <u>John Dippel</u>		4 DATE OF DEATH Month <u>Nov.</u> Day <u>7</u> Year <u>1967</u>	
5 SEX <u>Male</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>4/4/1879</u>
9 AGE (In years last birthday) <u>88</u> yrs		10 IF UNDER 1 YEAR Months <u>7</u> Days <u>19</u> Hours <u>67</u> Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SHIPPING AGENT</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>SELF EMPLOYED</u>	
11 BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13 FATHER'S NAME <u>CHRISTOPHER Dippel</u>		14. MOTHER'S MAIDEN NAME <u>ELIZABETH Ullrich</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16 SOCIAL SECURITY NO <u>212-32-8437</u>	
17 INFORMANT <u>John M. Kugel</u>		Address <u>252 E. Paul Ave</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Carcinomatosis (generalized)</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma Bladder</u> DUE TO (c) <u>2 yrs</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>no</u>		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>none</u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d INJURY OCCURRED Where <input type="checkbox"/> at work <input type="checkbox"/> Not Where <input type="checkbox"/> at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Aug 6, 1965</u> to <u>Nov 7, 1967</u> that (I) (we) lost saw the deceased alive on <u>Nov 7, 1967</u> , and that death occurred at <u>8 P.M.</u> from causes and on the date stated above.			
22a SIGNATURE <u>Maurice Feldman Jr.</u>		22b DATE SIGNED <u>11/9/67</u>	
22c PHYSICIAN'S NAME (Type) <u>Maurice Feldman Jr.</u>		22d ADDRESS <u>2 E READ ST. BALTO MD</u>	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b DATE THEREOF <u>11/10/67</u>	23c NAME OF CEMETERY OR CREMATORY <u>Green Lawn Cemetery</u>	23d LOCATION (City or Town) (County) (State) <u>BALTO. MD</u>
24 FUNERAL DIRECTOR <u>John A. Moran Inc</u>		25a REC'D BY REGISTRAR <u>Charles Judge</u>	
25b REG STRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>NOV 10 1967</u>	



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14932

## CERTIFICATE OF DEATH

14937

1 PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Timonium</b>		c. LENGTH OF STAY IN 15 <b>Yrs.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>111 Charmuth Rd.</b>		e. STREET ADDRESS <b>111 Charmuth Rd.</b>	
3 NAME OF DECEASED (Type or print) <b>J. Beverly Dooley</b> First Middle Last		4 DATE OF DEATH <b>Nov. 3, 1967</b> Month Day Year	
5 SEX <b>M</b>	6 COLOR OR RACE <b>Cauc.</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>3-15-1901</b>
9 AGE (in years birthday) <b>66</b> yrs		10a. USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ins. Adjuster</b>	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Roanoke, Va.</b>	
12 CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>		13. FATHER'S NAME <b>Robert Lee Dooley</b>	
14. MOTHER'S MAIDEN NAME <b>Lilian L. Oden</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>	
16. SOCIAL SECURITY NO. <b>232 14 5897</b>		17. INFORMANT <b>Jane Dooley, Timonium, Md.</b> Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>MYOCARDIAL INFARCTION</b> DUE TO (b) <b>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b> DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <b>4 mos</b>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>1960</b> , to <b>Nov. 3, 1967</b> , that (I) (we) last saw the deceased alive on <b>Nov 1, 1967</b> , and that death occurred at <b>2 A.M.</b> from causes and on the date stated above.			
22a SIGNATURE <b>William A. Pillsbury</b>		22b DATE SIGNED <b>Nov. 3 1967</b>	
22c PHYSICIAN'S NAME (Type) <b>Dr. William A. Pillsbury</b>		22d. ADDRESS <b>2060 York Road, Timonium, Maryland</b>	
23a BURIAL, CREMATION, REMOVAL (Specify) <b>Entombment</b>	23b. DATE THEREOF <b>Nov. 6, 67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Dulaney Valley</b>	23d. LOCATION (City or Town) (County) (State) <b>Cockeysville, Md. Baltimore</b>
24 FUNERAL DIRECTOR <b>Wm. Cook-Brooks Towson, Towson, Md. 21204</b>		25a. REC'D BY REGISTRAR DATE <b>NOV 7 1967</b>	
		25b REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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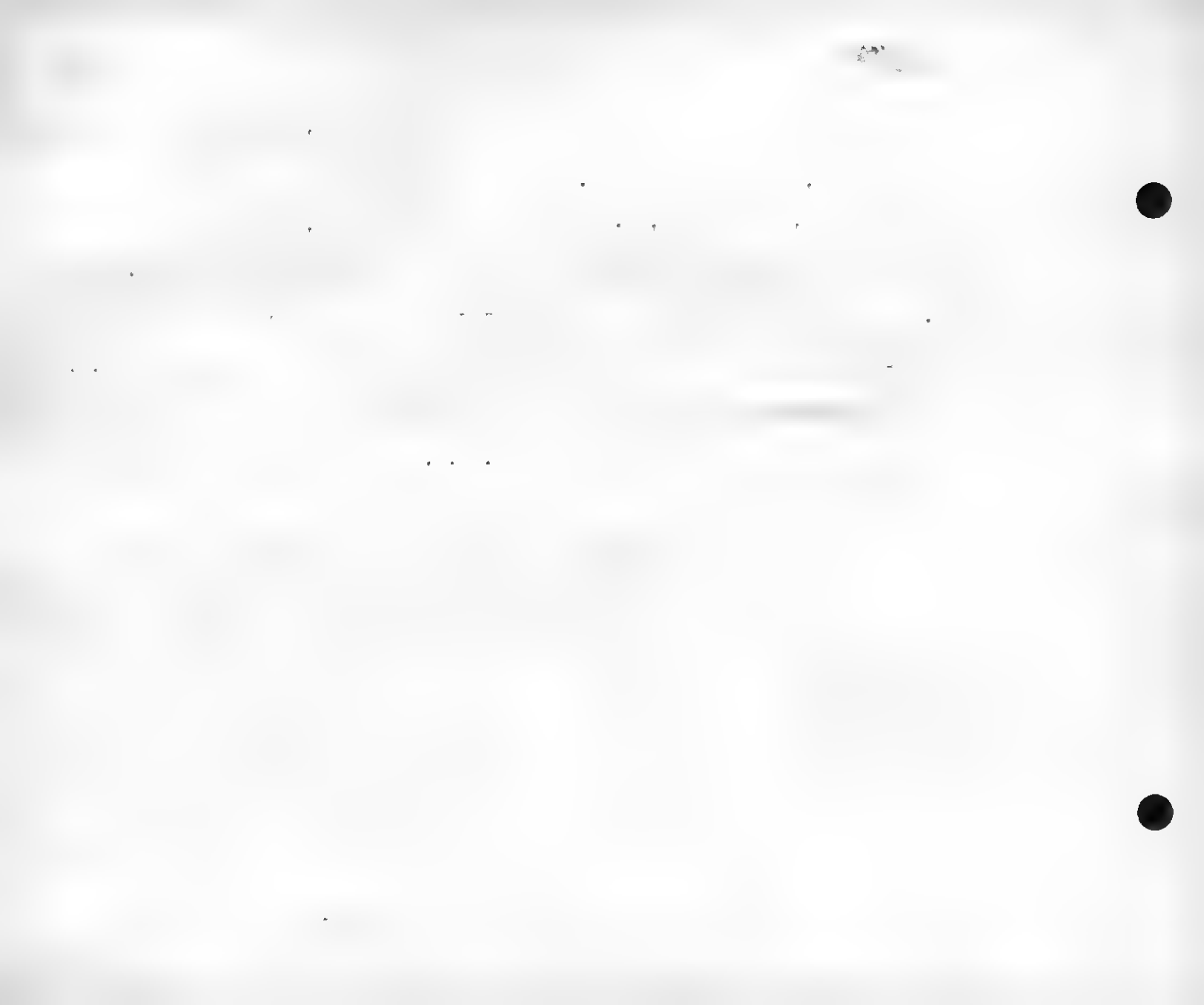
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14938

CERTIFICATE OF DEATH

14938

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lutherville.</b> c. LENGTH OF STAY IN 1b <b>5 yrs. - 30d.</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>COLLEGE MANOR, Lutherville, Md. 21093</b>		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>Carvel Hall, Maryland Anne Arundel</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b> d. STREET ADDRESS <b>Carvel Hall, HOTEL</b> e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Geraldine Richmond Dugan</b> First Middle Last		4. DATE OF DEATH <b>November 2nd., 1967</b> Month Day Year	
5. SEX <b>F.</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3-9-1873</b> 9. AGE (In years last birthday) <b>94</b> yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House-wife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>House-wife</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Cheyenne, Wyoming</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Henry Richmond W. WESSIDORS</b>		14. MOTHER'S MAIDEN NAME <b>McGinniss</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <b>215-48-6950</b>	
17. INFORMANT <b>Mrs. S.R. Clark, Annapolis, Maryland</b>		Address	
18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: <b>4500</b> IMMEDIATE CAUSE (a) <b>Probable pulmonary embolism</b> DUE TO (b) <b>Severe gen'l arteriosclerosis</b> DUE TO (c) <b>hypertension</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I. or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (1) (this hospital) attended the deceased from <b>May</b> , 19 <b>67</b> to <b>Nov</b> , 19 <b>67</b> ; that (1) (we) last saw the deceased alive on <b>11-2</b> , 19 <b>67</b> and that death occurred at <b>2A</b> M, from causes and on the date stated above			
22a. SIGNATURE <b>RK Gundry</b>		22b. DATE SIGNED <b>11-2-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>RK Gundry</b>		22d. ADDRESS <b>2W University Pkwy 21218</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>11/7/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>HEMINGTON NATIONAL CEM.</b>	23d. LOCATION (City or Town) (County) (State) <b>HEMINGTON, VA.</b>
24. FUNERAL DIRECTOR <b>Wm. Lock-Brooks TOWNSON 1050 York Bb.</b>		25a. REC'D BY REGISTRAR <b>NOV 7 1967</b> DATE	
		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



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1

MARYLAND STATE DEPARTMENT OF HEALTH

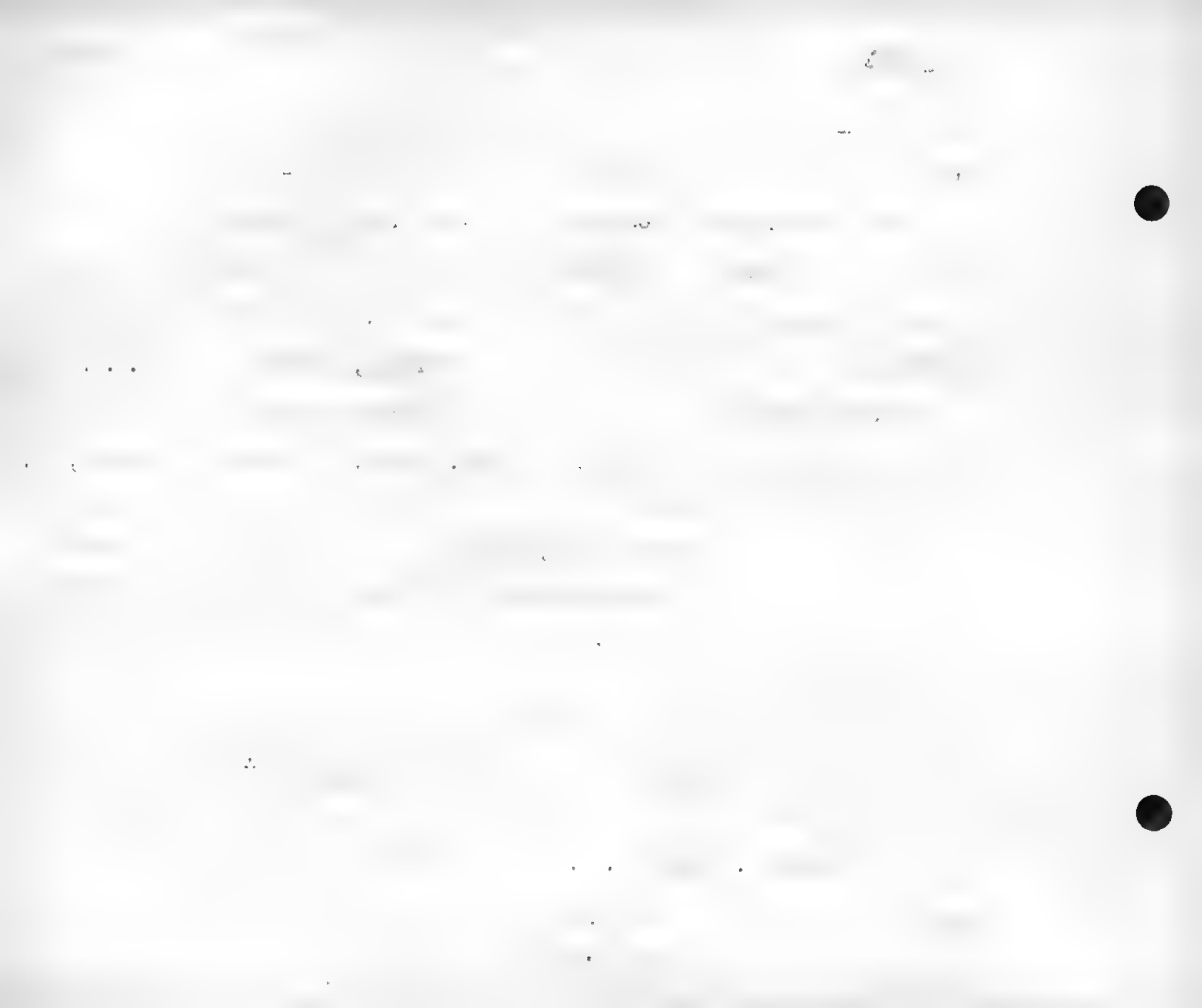
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14934

CERTIFICATE OF DEATH

14939

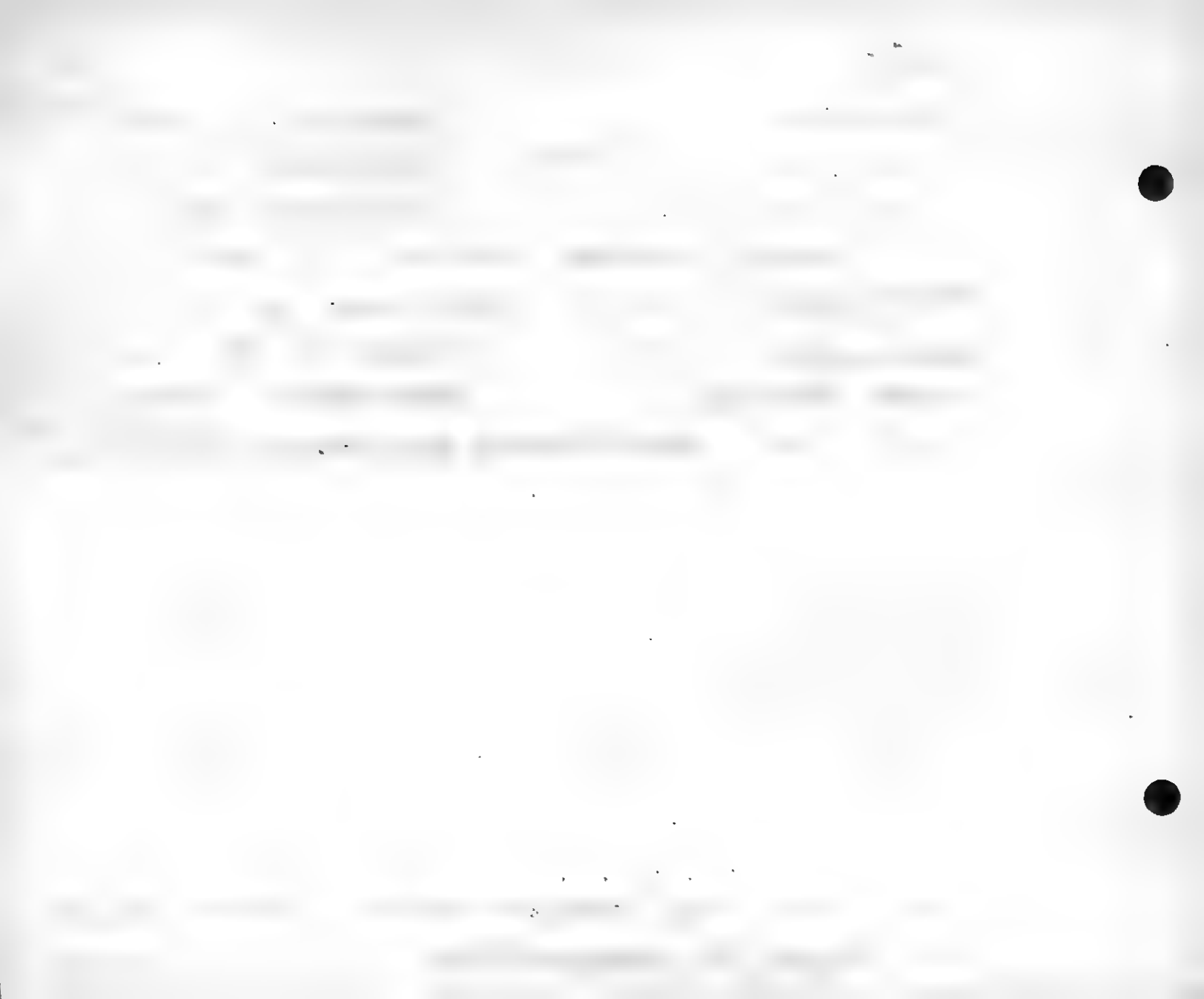
1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institut on Residence before admssion) a. STATE <b>MARYLAND</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>				c. LENGTH OF STAY IN 1b <b>91 DAYS</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>VETERANS ADMINISTRATION HOSPITAL</b>				e. STREET ADDRESS <b>1928 E. EAGER STREET</b>			
3. NAME OF DECEASED (Type or print) <b>WINDSOR STANFORD DUTTON</b>				4. DATE OF DEATH Month <b>NOVEMBER</b> Day <b>2</b> Year <b>19 67</b>			
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>NEGRO</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>OCTOBER 20, 1908</b> 59 yrs				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CHAUFFEUR</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State or foreign country) <b>WOODBINE, MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>CLARENCE DUTTON</b>				14. MOTHER'S MAIDEN NAME <b>CATHERINE CHRISTIAN</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>YES WW II</b>		16. SOCIAL SECURITY NO <b>212 20 93 78</b>		17. INFORMANT <b>CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>UREMIA</b> DUE TO (b) <b>DIABETIC NEPHROPATHY</b> DUE TO (c) <b>ARTERIOSCLEROTIC HEART DISEASE</b>						INTERVAL BETWEEN ONSET AND DEATH <b>RECENT</b> <b>UNKNOWN</b> <b>UNKNOWN</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>BENIGN PROSTATIC HYPERTROPHY. DIABETES MELLITUS, CLINICAL</b>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>8/3/67</b> , 19__ to <b>11/2/67</b> , 19__, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>11/2/67</b> , 19__, and that death occurred at <b>2:15 PM</b> , from causes and on the date stated above							
22a. SIGNATURE <i>Jorge A. Fabara</i>				MD. ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>11/2/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>JORGE A. FABARA, M. D.</b>				22d. ADDRESS <b>VAH FORT HOWARD, MARYLAND</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>11-6-67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Simpson Chapel Church Cemetery, Poplar Springs, Md.</b>		23d. LOCATION (City or Town) (County) (State)	
24. FUNERAL DIRECTOR <i>Elroy O. Wilson</i>				25a. REC'D BY REGISTRAR <b>NOV 7 1967</b>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



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VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>PIKESVILLE</b> c. LENGTH OF STAY IN b <b>10 YRS.</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>216 SLADE AVE.</b>					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>PIKESVILLE</b> d. STREET ADDRESS <b>216 SLADE AVE.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>NANCY EMALINE EBAUGH</b>			4. DATE OF DEATH <b>NOV. 2 1967</b>		5. SEX <b>FEMALE</b>				
6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>OCT. 17 1893</b>		9. AGE (In years last birthday) <b>74</b> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSE-WIFE</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>CARROLL CO. MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>EARL ARNOLD</b>					14. MOTHER'S MAIDEN NAME <b>MARGARET ARNOLD?</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO. <b>212-07-2174</b>		17. INFORMANT <b>MRS. DORIS BAILEY PIKESVILLE, MD.</b>			Address <b>216 SLADE AVE.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of the rectum with metastases</b> DUE TO (b) DUE TO (c) CONDITIONS, If any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (b) <b>Arteriosclerotic Heart Disease</b> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <b>AUG. 2, 1967</b> to <b>11/2, 1967</b> , that (I) (we) last saw the deceased alive on <b>10/31, 1967</b> , and that death occurred at <b>9:30 AM</b> , from the causes and on the date stated above.									
22a. SIGNATURE <b>Bernard Burgin</b>					22b. DATE SIGNED <b>11/2/67</b>		22c. PHYSICIAN'S NAME (Type) <b>BERNARD BURGIN, M.D.</b>		
22d. ADDRESS <b>6721 Reisterstown Rd. Balto. Md.</b>					22e. MED. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>			23b. DATE THEREOF <b>NOV. 4, 1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>CARROLLTON CEMETERY</b>		23d. LOCATION (City, town or county) (State) <b>FINKSBURG RD. MD.</b>		
24. FUNERAL DIRECTOR <b>J. E. Mays, Jr., Westminster, Md.</b>					25a. REC'D BY REGISTRAR <b>NOV 7 1967</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

14935

Item #16 Film #334-11/14/67 ph

CERTIFICATE OF DEATH

14341

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Essex (21)</b> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>800 Back River Neck Rd.</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Essex (21)</b> d. STREET ADDRESS <b>800 Back River Neck Rd.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Gustav</b> Middle <b>Adolph</b> Last <b>Ebersberger</b>				4. DATE OF DEATH Month <b>November</b> Day <b>1</b> Year <b>1967</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Nov. 14, 1891</b>	
9. AGE (In years last birthday) <b>75</b> yrs.		10. FUND 1 YEAR Months <b>75</b> Days <b>75</b> Hours <b>75</b> Min.		11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Merchant</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>General Store</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore, Maryland</b>	
13. FATHER'S NAME <b>Michael Ebersberger</b>				14. MOTHER'S MAIDEN NAME <b>Helena Schafer</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>21-32-8413</b> <b>920/50/8360</b>		17. INFORMANT <b>Margaret Ebersberger</b> Address <b>Same</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia</b> DUE TO (b) <b>Pulmonary Emboli</b> DUE TO (c) <b>Arteriosclerotic Cardio-vascular disease</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <b>2 1/2 hrs</b> <b>1 wk</b> <b>2 years</b>	
						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
						20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Jan 1, 1967</b> to <b>Nov 1, 1967</b> , that (I) (we) last saw the deceased alive on <b>Oct 31, 1967</b> , and that death occurred at <b>9 P</b> M, from the causes and on the date stated above.							
22a. SIGNATURE <b>G. M. Baumgardner</b> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>11-1-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>G. M. Baumgardner</b>				22d. ADDRESS <b>Balto 21237</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11/6/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Oak Lawn Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Baltimore Co., Md.</b>	
24. FUNERAL DIRECTOR <b>Prudzinski Funeral Home</b> ADDRESS <b>1407 Eastern Ave.</b>				25a. REC'D BY REGISTRAR <b>NOV 6 1967</b> 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			





MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14937

CERTIFICATE OF DEATH

14942

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 4 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a STATE <u>Md.</u> b COUNTY <u>1</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> c3	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Shangri-La Nursing Home</u>		d. STREET ADDRESS <u>1003 Flagtree Lane</u>	
3. NAME OF DECEASED (Type or print) First <u>FRANK</u> Middle <u>EBLINE</u> Last <u>EBLINE</u>		4. DATE OF DEATH Month <u>Nov.</u> Day <u>30</u> Year <u>19 67</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>Wh</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/27/85</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) yrs <u>82</u>
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO <u>217-34-2884</u>	17. INFORMANT <u>R. Douglas v. Eblin</u> Address <u>1003 Flagtree Lane</u>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: <u>4221</u> IMMEDIATE CAUSE (a) <u>atherosclerotic CV Disease</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <u>3 YRS.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS A TOLPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>9-3</u> , 19 <u>65</u> to <u>11/30</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>11/29</u> , 19 <u>67</u> , and that death occurred <u>12:00 PM</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>John F. Schaefer</u>		22b. DATE SIGNED <u>11/30/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>JOHN F. SCHAEFER MD</u>		22d. ADDRESS <u>401 RANDOLM RD. BALTO. 21229</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>12-4-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cem.</u>	23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Md.</u>
24. FUNERAL DIRECTOR <u>Wickke F. D. - 4101 Randolph Ave.</u>		25a. REC'D BY REGISTRAR DATE <u>DEC 1 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>John Charles Judge</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.  
Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)  
25M 1/67

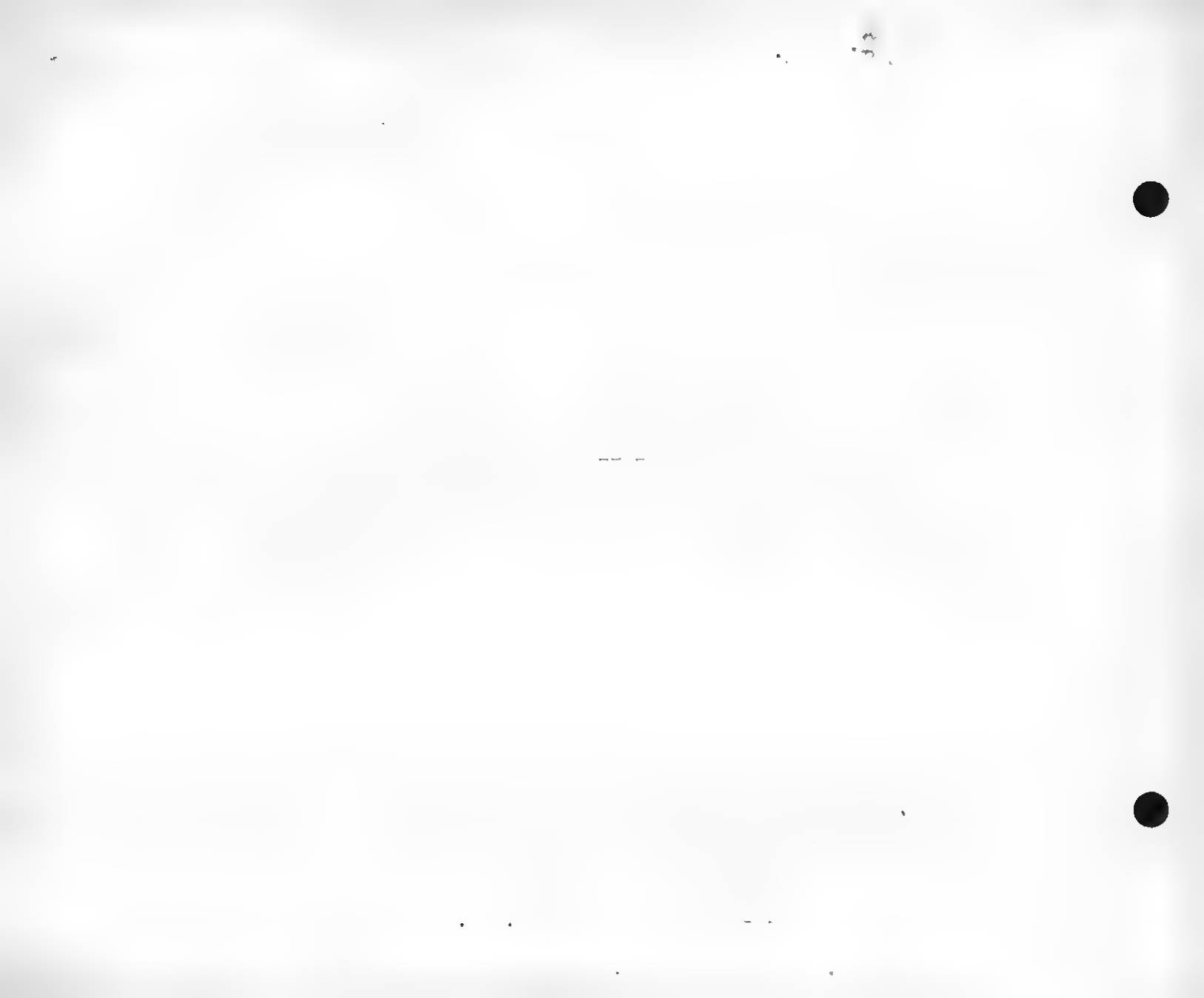
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14938

CERTIFICATE OF DEATH

14943

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt. Wilson</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
c. LENGTH OF STAY IN 1b <b>359 days</b>		d. STREET ADDRESS <b>1905 Lafayette Ave</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Mt. Wilson State Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>SAVANNAH First JANE Middle Last EDWARDS</b>		4. DATE OF DEATH Month <b>11</b> Day <b>3</b> Year <b>1967</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9.14.1904</b>
9. AGE (In years last birthday) <b>63</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	11. BIRTHPLACE (Country & State, or foreign country) <b>South Carolina</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>LEE JOY</b>	
14. MOTHER'S MAIDEN NAME <b>ANNA ANDERSON</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	
16. SOCIAL SECURITY NO <b>212-10-2399</b>		17. INFORMANT Address <b>Records, Mt. Wilson State Hospital</b>	
18. CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Terminal massive hemorrhage</b> DUE TO (b) <b>Far advanced pulmonary tuberculosis</b> DUE TO (c) <b>5 years</b>		INTERVAL BETWEEN ONSET AND DEATH <b>10 min</b>	
PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>11-9</b> , 19 <b>66</b> , to <b>11-3</b> , 19 <b>67</b> that (I) (we) last saw the deceased alive on <b>11-3</b> , 19 <b>67</b> and that death occurred at <b>11-3</b> , 19 <b>67</b> M, from causes and on the date stated above			
22a. SIGNATURE <b>W. Newcomer</b>		22b. DATE SIGNED <b>11.3.1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>Wm. Newcomer, M.D., Supt.</b>		22d. ADDRESS <b>Mt. Wilson, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11-6-67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Arbutus Mem. Pk.</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Maryland</b>	
24. FUNERAL DIRECTOR ADDRESS <b>Arlington S. Phillips 1727 N. Monroe Street</b>		25a. REC'D BY REGISTRAR DATE <b>NOV 7 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



14939

## CERTIFICATE OF DEATH

14944

1 PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Owings Mills</b>		c. LENGTH OF STAY IN lb <b>1 mon. 16 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Rosewood State Hospital</b>		d. STREET ADDRESS <b>820 Robbins Street</b>	
3 NAME OF DECEASED (Type or print) <b>Lacurtis Timothy Farrare</b>		4 DATE OF DEATH Month <b>II</b> Day <b>27</b> Year <b>1967</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6-25-62</b>
9. AGE (In years lost birthday) <b>5</b> yrs		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>none</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Dorchester, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Lacurtis Henry Farrare</b>		14. MOTHER'S MAIDEN NAME <b>Barbara Ethel Pinkett</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Rosewood's Records</b>		Address <b>Owings Mills, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>tracheo-bronchial obstruction, pneumonia</b> <b>192x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>interstitial pneumonia</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>10 Days</b>		PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Institutionalization 1 mon 16 days Profound Mental Retardation</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (X) (this hospital) attended the deceased from <b>10/11</b> , 1967, to <b>11/27</b> , 1967, that (X) (we) last saw the deceased alive on <b>11/27</b> , 1967, and that death occurred at <b>5:05</b> <b>PM</b> on causes and on the date stated above.			
22a. SIGNATURE <b>Richard A. Jones</b>		22b. DATE SIGNED <b>11-28-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Richard A. Jones, M.D.</b>		22d. ADDRESS <b>Rosewood State Hosp., Owings Mills, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12-1-67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Reids Grove Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Near Reids Grove, Maryland</b>	
24. FUNERAL DIRECTOR <b>Trampton Funeral Home Federalsburg Md</b>		25a. REC'D BY REGISTRAR <b>NOV 30 1967</b>	
25b. REGISTRAR'S SIGNATURE			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Balto</u> <u>md.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>md</u> b. COUNTY <u>CARROLL</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Balto</u>		c. LENGTH OF STAY IN 1b <u>11</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Caton Ridge Nursing Home</u>		d. STREET ADDRESS <u>11</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Guy</u> <u>Lewis</u> <u>Favorite</u>		4. DATE OF DEATH Month Day Year <u>11</u> <u>26</u> <u>1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOW <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-9-90</u>
9. AGE (In years last birthday) <u>77</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CARPENTER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>link</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>HENRY Favorite</u>		14. MOTHER'S MAIDEN NAME <u>SALLY SHINDLEDECKER</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>213-18-0144</u>	
17. INFORMANT <u>Nursing Home Chap</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO (b) <u>Arteriosclerosis</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Atrial Fibrillation</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>30 yrs</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>10/15</u> , 19 <u>67</u> , to <u>11/26</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>11/26</u> , 19 <u>67</u> , and that death occurred at <u>12:45</u> PM, from the causes and on the date stated above.			
22a. SIGNATURE <u>David E. Zickatose</u>		22b. DATE SIGNED <u>11/26/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>David E. Zickatose</u>		22d. ADDRESS <u>4 VFW Lane, Ellicott City, Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Nov. 30, 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>St. Anthony's Shrine</u>		23d. LOCATION (City, town or county) (State) <u>Bruttsburg, Frederick Co. Md.</u>	
24. FUNERAL DIRECTOR <u>Clarence E. Wilson</u>		ADDRESS <u>Bruttsburg, Md.</u>	
25a. REC'D BY REGISTRAR <u>NOV 29 1967</u>		25b. REGISTRAR'S SIGNATURE <u>James Judge</u>	





# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If City deary is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14941

14946

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Essex (21)</b>		c. LENGTH OF STAY IN IS		c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <b>Essex (21)</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Marine Basin Marina 1900 Eastern Ave.</b>			d. STREET ADDRESS <b>315 Endsleigh Ave.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>NEIL DONALD FAWBUSH</b>			4. DATE OF DEATH Month <b>November</b> Day <b>2</b> Year <b>1967</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 3, 1923</b>		9. AGE (In years lost birthday) <b>44</b> yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Owner- Operator</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Service Station</b>		11. BIRTHPLACE (State or foreign country) <b>W. Va.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			13. FATHER'S NAME <b>Clyde W. Fawbush</b>		
14. MOTHER'S MAIDEN NAME <b>Nellie Gilbert</b>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes WWII</b>		
16. SOCIAL SECURITY NO <b>234 20 5328</b>		17. INFORMANT <b>Ruth R. Fawbush Same</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CORONARY OCCLUSION</b> DUE TO <b>ART-VE-DISEASE</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) (c) PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>None</b>					INTERVAL BETWEEN ONSET AND DEATH <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work or Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>M B Davis</b>		22. DATE SIGNED <b>11/2/67</b>			
EXAMINER'S NAME (Type) <b>M. B. Davis, M. D. 6800 Mornington Rd. Dundalk, Md.</b>		23a. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>			
23b. DATE THEREOF <b>11/6/67</b>		23c. LOCATION (City or Town) <b>Baltimore, Md.</b>		23d. LOCATION (County) (State)	
24. FUNERAL DIRECTOR <b>Bruzdinski Funeral Home</b>		ADDRESS <b>1407 Eastern Ave.</b>		25a. REC'D BY REGISTRAR <b>NOV 6 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>					



## CERTIFICATE OF DEATH

14847

14842

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANDALSTOWN</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Baltimore County General</u>		d. STREET ADDRESS <u>2913 SILVER HILL AVENUE #7</u>	
3. NAME OF DECEASED (Type or print) <u>JEANETTE Fink</u>		4. DATE OF DEATH <u>Nov. 27</u> 19 <u>67</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>XXXXXX</u>
9. AGE (In years) <u>77</u> (lost birthday) <u>XX</u> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>		11. BIRTH PLACE (County & State, or foreign country) <u>LITHUANIA</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>WOLF WEINBERG</u>	
14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <u>No</u>	
16. SOCIAL SECURITY NO. <u>XXXXXX</u>		17. INFORMANT <u>Milton A. Fink</u> Address <u>5100 CHALGROVE AVE #15</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>170x Pulmonary metastases</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>Carcinoma of the breast</u> (b) <u>Due to</u> (c) <u>Due to</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>11-7-67</u> , 19 <u>67</u> to <u>11-27</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>11-27</u> , 19 <u>67</u> , and that death occurred at <u>7:00 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Charles J. Venturana</u>		22b. DATE SIGNED <u>11-27-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>VENTURANA</u>		22d. ADDRESS <u>Baltimore County Gen. Hosp.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>11-28-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>DHR KNESSETH ISRAEL ANSHE SFARD</u>	23d. LOCATION (City or Town) (County) (State) <u>BALTIMORE, MARYLAND</u>
24. FUNERAL DIRECTOR <u>Sal. Lenson Bros.</u> ADDRESS <u>6010 REISTERSTOWN</u>		25a. REC'D BY REGISTRAR <u>DEC 5 1967</u> 25b. REGISTRAR'S SIGNATURE <u>Charles J. Venturana</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14948

14948

1. PLACE OF DEATH a COUNTY <b>BALTIMORE</b> MARYLAND			2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a STATE <b>M.D.</b> b COUNTY		
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CATONSVILLE</b>		c LENGTH OF STAY IN 1b	c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>710 WOODSDALE RD.</b>		
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>710 WOODSDALE RD.</b>			d STREET ADDRESS <b>CATONSVILLE, M.D. 21228</b>		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3 NAME OF DECEASED (Type or print) First <b>JOSEPH</b> Middle <b>C.</b> Last <b>FISCHER</b>			4 DATE OF DEATH Month <b>NOV.</b> Day <b>20</b> Year <b>1967</b>		
5 SEX <b>M</b>	6 COLOR OR RACE <b>W</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>AUG 17, 1877</b>		9 AGE (In years last birthday) <b>90 yrs</b>
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SALESMAN</b>		10b KIND OF BUSINESS OR INDUSTRY <b>HEATS</b>		11 BIRTHPLACE (County & State, or foreign country) <b>M.D.</b>	
13 FATHER'S NAME <b>GOTTLIEB FISCHER</b>			14 MOTHER'S MAIDEN NAME <b>GERTRUDE</b>		
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes give war or dates of service)		16 SOCIAL SECURITY NO. <b>216-09-0108</b>		17 INFORMANT Address <b>Joseph Fischer - 710 Woodsdale Ave.</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebrovascular thrombosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic cardiovascular disease</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b> <b>5 yrs +</b>					
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <b>19</b>		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
		20f (City or town)		(County) (State)	
21. I certify that (I) (the hospital) attended the deceased from <b>Oct. 19, 1962</b> , to <b>Nov 20, 1967</b> , that (I) (we) last saw the deceased alive on <b>Nov 20, 1967</b> , and that death occurred at <b>2:00 P.M.</b> , from causes and on the date stated above.					
22a SIGNATURE <b>John A. Nesbitt, Jr.</b>			22b DATE SIGNED <b>11-21-67</b>		
22c PHYSICIAN'S NAME (Type) <b>John A. Nesbitt, Jr., M.D.</b>			22d ADDRESS <b>1009 Frederick Road</b>		
23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE THEREOF	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION (City or Town) (County) (State)		
<b>Burial</b>	<b>11-25-1967</b>	<b>Cathedral Cem.</b>	<b>Baltimore Md.</b>		
24 FUNERAL DIRECTOR <b>Farley-Cornough &amp; Son, Catonsville, Md.</b>			25a REC'D BY REGISTRAR DATE <b>NOV 24 1967</b>		25b REGISTRAR'S SIGNATURE <b>John Charles Judge</b>



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14844

## CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson 4</b> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>St. Joseph Hospital</b>		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>7 Greenwood Avenue</b> d. STREET ADDRESS <b>Baltimore 21206</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <b>MARY TERESA FOLEY</b> First Middle Last 4 DATE OF DEATH <b>November 11, 1967</b> Month Day Year		5 SEX <b>Female</b> 6 COLOR OR RACE <b>White</b> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8 DATE OF BIRTH <b>November 1, 1908</b> 9 AGE (In years last birthday) <b>59</b> Yrs IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Social Worker</b> 10b. KIND OF BUSINESS OR INDUSTRY <b>Childrens Aid</b> 11. BIRTHPLACE (County & State or foreign country) <b>England</b> 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Thomas Bernard Foley</b> 14. MOTHER'S MAIDEN NAME <b>Catherine Cunningham</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b> 16. SOCIAL SECURITY NO. <b>213-34-0031</b> 17. INFORMANT <b>Thomas J. Cramblitt 7 Greenwood Avenue</b> Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cardio-pulmonary failure</b> <b>172x</b> DUE TO <b>Metastatic carcinoma of the breast</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b> 20c. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work 20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20e. (City or town) (County) (State)		20f. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
21. I certify that <del>the</del> (this hospital) attended the deceased from <b>October 28, 1967</b> , to <b>November 11, 1967</b> , that <del>we</del> (we) last saw the deceased alive on <b>November 11, 1967</b> , and that death occurred at <b>9:10 a.m.</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>Benjamin V. del Carmen M.D.</b> 22c. PHYSICIAN'S NAME (Type) <b>Benjamin del Carmen, M. D.</b>		22b. DATE SIGNED <b>11/11/1967</b> 22d. ADDRESS <b>7620 York Road, Towson 4, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b> 23b. DATE THEREOF <b>Nov 14 1967</b> 23c. NAME OF CEMETERY OR CREMATORY <b>Gardens of Faith Cem</b> 23d. LOCATION (City or Town) (County) (State) <b>Trumps Mill Rd Balto MD</b>		24. FUNERAL DIRECTOR <b>THE DIPPEL BROS INC 7110 BELAIR RD</b> ADDRESS 25a. REC'D BY REGISTRAR <b>NOV 14 1967</b> 25b. REGISTRAR'S SIGNATURE <b>William Judge</b>	





MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14845

14550

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Phoenix, Balto. Co.</b> c. LENGTH OF STAY IN 1b		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Phoenix, Baltimore Co.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>19 Glenbrook Drive</b>		d. STREET ADDRESS <b>19 Glenbrook Drive</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <b>JAMES H. FORBES</b> First Middle Last		4 DATE OF DEATH <b>Nov. 18th</b> Month Day Year	
5 SEX <b>Male</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>April 20, 1921</b> 9 AGE (In years last birthday) <b>46 yrs</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Self-employed</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Trailer Park Prop.</b>	
11 BIRTHPLACE (County & State, or foreign country) <b>Baltimore, Md.</b>		12 CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>James H. Forbes 2nd</b>		14. MOTHER'S MAIDEN NAME <b>Viola Bennett</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>220-05-8131</b>	
17 INFORMANT <b>Mrs. Janet M. Forbes-19 Glenbrook Dr.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory arrest</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Malignant glioma</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <b>9 months</b>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>February, 19 67</b> , to <b>Nov. 17, 19 67</b> , that (I) (we) last saw the deceased alive on <b>Nov. 17, 19 67</b> , and that death occurred at <b>1:4-M</b> , from causes and on the date stated above.			
22a SIGNATURE <b>Donald O. Wood M.D.</b>		22b DATE SIGNED <b>11-20-67</b>	
22c PHYSICIAN'S NAME (Type) <b>Donald O. Wood M.D.</b>		22d ADDRESS <b>York &amp; Greenmeadow Rds.</b>	
23a BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b DATE THEREOF <b>11/21/67</b>	23c NAME OF CEMETERY OR CREMATORY <b>Clynmalira Meth. Cem.</b>	23d LOCATION (City or Town) (County) (State) <b>Baltimore Co.</b>
24 FUNERAL DIRECTOR <b>Mitchell-Wiedefeld Home-6500 York Rd. 21212</b>		25a REC'D BY REGISTRAR <b>NOV 24 1967</b> 25b REGISTRAR'S SIGNATURE <b>William J. Page</b>	



1

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

22846

14851

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cotonsville</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>2220 Westchester Avenue</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cotonsville</u> d. STREET ADDRESS <u>2220 Westchester Ave</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Herbert M Foster</u>				4. DATE OF DEATH <u>Nov 24</u> 19 <u>67</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 27 1888</u>	9. AGE (in years last birthday) <u>79</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Physician</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Lawrence B Foster</u>				14. MOTHER'S MAIDEN NAME <u>Laura J. Tilghman</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>220 443368</u>		17. INFORMANT <u>Elizabeth F Lehmann</u> Address <u>2220 Westchester Ave</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary artery disease</u> DUE TO (b) <u>arteriosclerosis with nephritis</u> DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH <u>6 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>June</u> , 19 <u>64</u> , to <u>Nov 24</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Sept 12</u> , 19 <u>67</u> , and that death occurred at <u>2220</u> M. from the causes and on the date stated above.							
22a. SIGNATURE <u>Robert B Taylor MD</u>				22b. DATE SIGNED <u>11-25-67</u>			
22c. PHYSICIAN'S NAME (Type) <u>Robert B Taylor</u>				22d. ADDRESS <u>Ellicott City, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>11-25-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge Cem</u>		23d. LOCATION (City, town or county) (State) <u>Pikesville Baltimore MD</u>	
24. FUNERAL DIRECTOR <u>Burgess Funeral Home</u>				25a. REC'D BY REGISTRAR <u>NOV 29 1967</u>		25b. REGISTRAR'S SIGNATURE <u>James J. Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

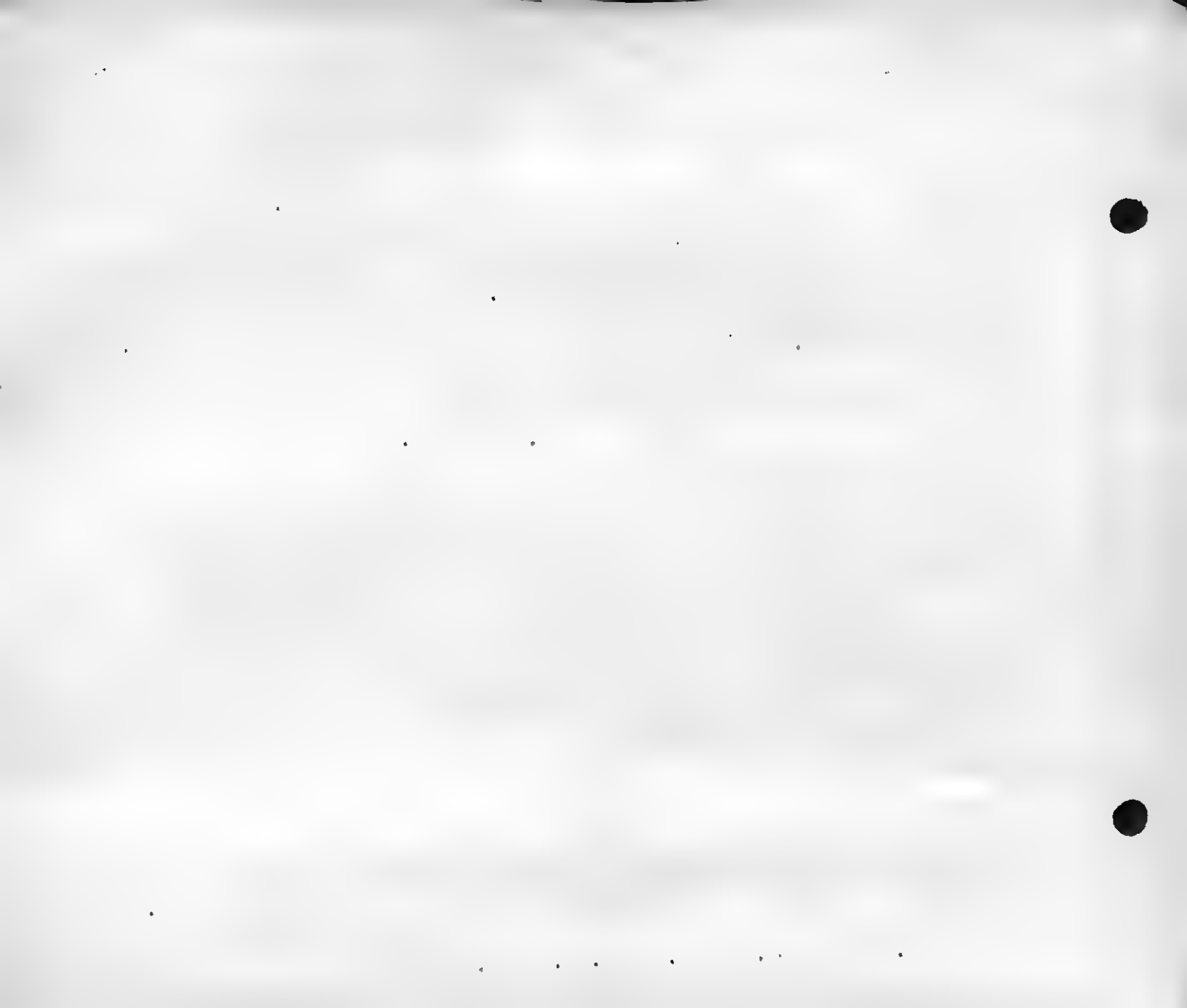
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div style="text-align: center;"> <b>MARYLAND STATE DEPARTMENT OF HEALTH</b>  <b>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</b>  <b>CERTIFICATE OF DEATH</b> </div>									
<b>1. PLACE OF DEATH</b> a. COUNTY <u>Baltimore</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore 21212</u> c. LENGTH OF STAY IN 1b <u>years</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>12 St. Michael's Way</u>					<b>2. USUAL RESIDENCE</b> (Where deceased lived, If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore 21212</u> d. STREET ADDRESS <u>12 St. Michael's Way</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
<b>3. NAME OF DECEASED</b> (Type or print) <u>JEFFREY SCOTT FOSTER</u> First Middle Last					<b>4. DATE OF DEATH</b> <u>November 3, 19 67</u> Month Day Year				
<b>5. SEX</b> <u>Male</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>Feb. 19, 1954</u>		<b>9. AGE</b> (In years last birthday) <u>13</u> yrs. IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Student</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>School</u>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Maryland</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>	
<b>13. FATHER'S NAME</b> <u>Charles Edward Foster</u>					<b>14. MOTHER'S MAIDEN NAME</b> <u>Patricia Murphy</u>				
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service)				<b>16. SOCIAL SECURITY NO.</b> <u>NONE</u>		<b>17. INFORMANT</b> <u>Patricia M. Foster, Same as # 2</u> Address			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <b>PART I. DEATH WAS CAUSED BY:</b>            IMMEDIATE CAUSE (a) <u>Virus chest infection</u>            DUE TO (b) <u>  </u>            Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>  </u>  <b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>  <u>Muscular dystrophy</u> </div> <div style="width: 45%;"> <b>INTERVAL BETWEEN ONSET AND DEATH</b>  <u>2 days</u> </div> </div>									
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>			<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)		
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>Feb. 19, 1954</u> <b>to</b> <u>Nov. 3, 19 67</u> <b>that (I) (we) last saw the deceased alive on</b> <u>Nov. 2, 19 67</u> <b>and that death occurred at</b> <u>3:00 PM</u> <b>from the causes and on the date stated above.</b>									
<b>22a. SIGNATURE</b> <u>E. Ellsworth Cook</u>						<b>22b. DATE SIGNED</b> <u>Nov. 4, 1967</u>		<b>22c. PHYSICIAN'S NAME (Type)</b> <u>E. Ellsworth Cook, M.D.</u>	
<b>22d. ADDRESS</b> <u>2431 Maryland Ave., Baltimore, Md.</u>		<b>22e. MED. PHYS.</b> <input checked="" type="checkbox"/> <b>M.D.</b> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>							
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>			<b>23b. DATE THEREOF</b> <u>Nov. 4, 1967</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Dulaney Valley Cemetery</u>		<b>23d. LOCATION (City, town or county)</b> (State) <u>Cockeysville, Maryland</u>		
<b>24. FUNERAL DIRECTOR</b> <u>Wm. Cook-Brooks Towson, 1050 York Road</u> <u>Towson, Maryland 21204</u>						<b>25a. REC'D BY REGISTRAR</b> <u>NOV 7 1967</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>Charles Judge</u>	

MEDICAL CERTIFICATION









14848

## CERTIFICATE OF DEATH

14854

1 PLACE OF DEATH a COUNTY <u>Baltimore</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkville</u>		c LENGTH OF STAY IN lb <u>Parkville</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>2621 Linwood Road</u>		d STREET ADDRESS <u>2621 Linwood Road</u>	
3 NAME OF DECEASED (Type or print) First <u>Edna</u> Middle <u>E</u> Last <u>Jreno</u>		4 DATE OF DEATH Month <u>Nov.</u> Day <u>28</u> Year <u>1967</u>	
5 SEX <u>female</u>	6 CO. OR OR RACE <u>white</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>Feb. 25, 1908</u>
9 AGE (In years last birthday) yrs <u>59</u>		F UNDER 1 YEAR Months Days Hours Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (County & State or foreign country) <u>Cambridge, Maryland</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Rhea</u>		14. MOTHER'S MAIDEN NAME <u>Annie Theiss</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16 SOCIAL SECURITY NO	
17 INFORMANT <u>Michael A. Jreno</u>		Address <u>same</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Adenocarcinoma of uterus</u> <u>171</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) <u>with metastasis to pelvis</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Post Cobalt therapy - enteritis vomiting</u>			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>March 14, 1949</u> to <u>Nov. 28, 1967</u> , that (I) (we) last saw the deceased alive on <u>Nov. 27, 1967</u> , and that death occurred at <u>6:50 AM</u> , from causes and on the date stated above			
22a SIGNATURE <u>H. V. Harbold</u>		22b DATE SIGNED <u>Nov. 28, 1967</u>	
22c PHYSICIAN'S NAME (Type) <u>H. V. HARBOLD M.D.</u>		22d ADDRESS <u>4706 Harford Road Baltimore, Maryland</u>	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	23b DATE THEREOF <u>12/1/67</u>	23c NAME OF CEMETERY OR CREMATORY <u>Parkwood Cemetery</u>	23d LOCATION (City or Town) (County) (State) <u>Baltimore, Md.</u>
24. FUNERAL DIRECTOR <u>Leonard J. Ruck, Inc Baltimore, Md.</u>		25a REC'D BY REGISTRAR DATE <u>NOV 29 1967</u>	
25b REGISTRAR'S SIGNATURE <u>[Signature]</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

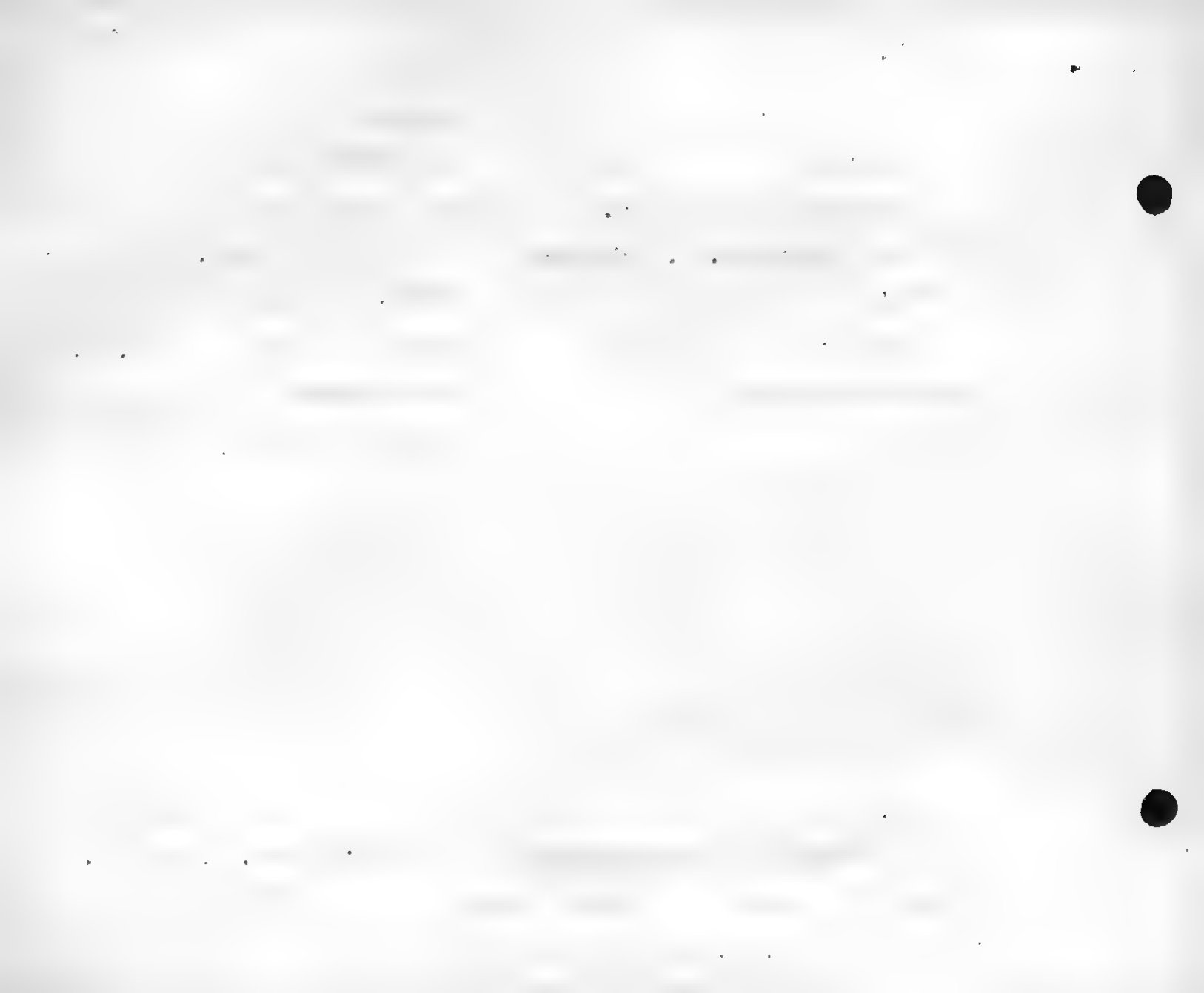
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Pikesville</b>			c. LENGTH OF STAY IN 1b <b>3yrs; 9mos</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Professional House, Inc.</b>					d. STREET ADDRESS <b>6011 Pimlico Rd.</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Fannie M. W. Friedman</b>			First Middle Last		4. DATE OF DEATH <b>Nov. 23, 1967</b>		Month Day Year		
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>11/20/74</b>		9. AGE (In years last birthday) <b>93</b> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>AT HOME</b>		11. BIRTHPLACE (County & State, or foreign country) <b>BALTIMORE, MARYLAND</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>David Wiesenfeld</b>					14. MOTHER'S MAIDEN NAME <b>SARAH Metzger</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>			16. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT <b>MR. STANFORD ROTHSCHILD, JR.</b>			Address <b>CHARLES CENTER SUN LIFE BUILDING</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>intercoronary heart disease</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertension cardiovascular disease</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								INTERVAL BETWEEN ONSET AND DEATH <b>15 years</b> <b>20 years</b>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <b>1950</b> to <b>March 23, 1967</b> , that (I) (we) last saw the deceased alive on <b>March 16, 1967</b> , and that death occurred at <b>6 A</b> M, from the causes and on the date stated above.									
22a. SIGNATURE <b>Herbert R. Gundersheimer</b>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>11/23/67</b>		
22c. PHYSICIAN'S NAME (Type) <b>Herbert R. Gundersheimer</b>					22d. ADDRESS <b>Riviera Apts. Balto., Md.</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>11-26-67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>BALTIMORE HEBREW</b>			23d. LOCATION (City, town or county) (State) <b>BALTIMORE, MARYLAND</b>		
24. FUNERAL DIRECTOR <b>SOL LEVINSON &amp; BROS. INC.</b>					ADDRESS <b>6010 REISTERSTOWN ROAD</b>		25a. REC'D BY REGISTRAR <b>NOV 28 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles J. [Signature]</b>



TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. Page 2 should be retained by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)  
15M 7/61

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

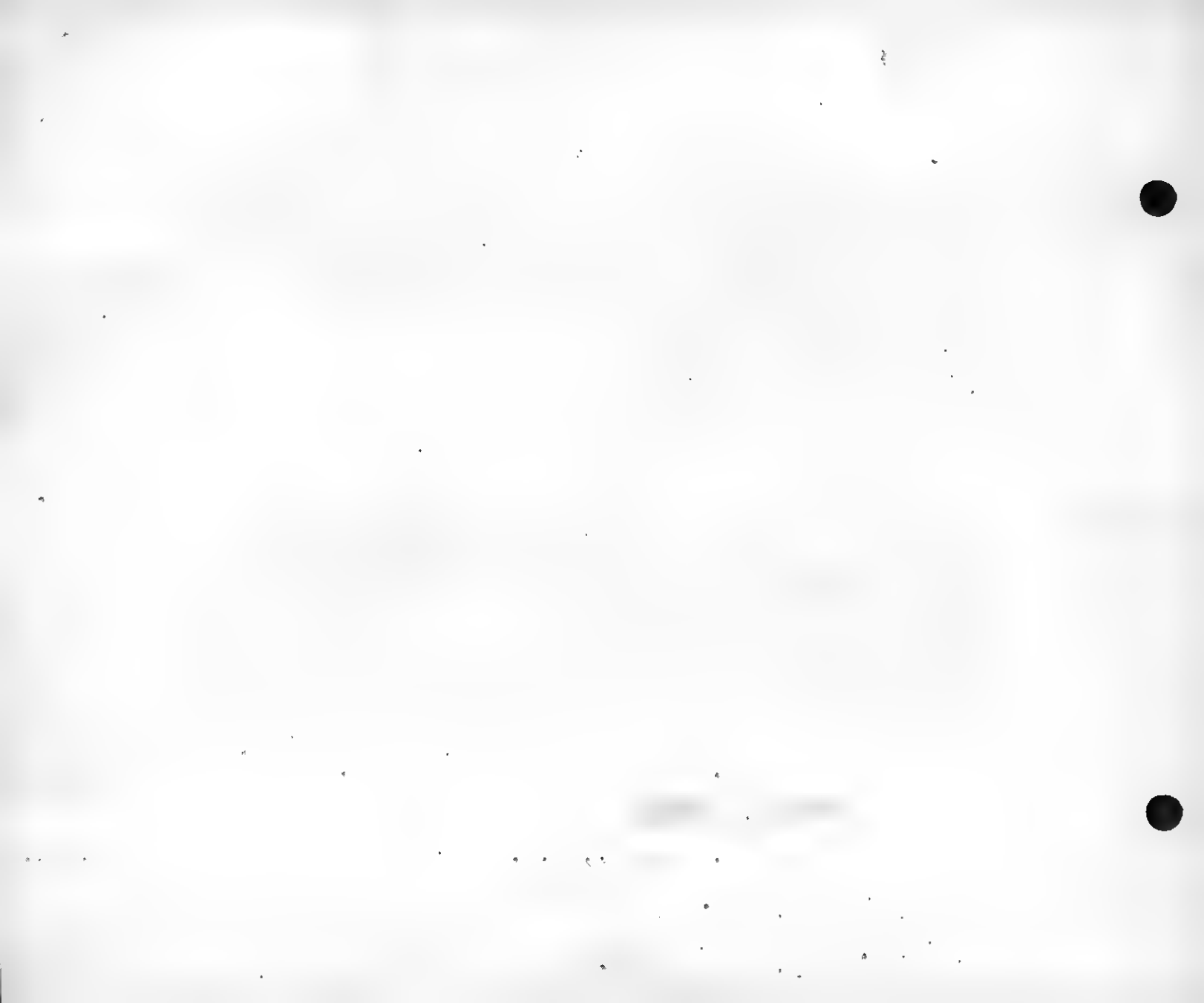
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>BANDALLSTOWN</u> c. LENGTH OF STAY IN 1b <u>1</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>BALTO. Co. Gen. Hosp.</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BAIT.</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u> d. STREET ADDRESS <u>21307 3503 MAYFAIR Rd</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First <u>MARTIN</u> Middle <u>DAVID</u> Last <u>Fuhrman</u>	4. DATE OF DEATH Month <u>11</u> Day <u>6</u> Year <u>1967</u>	5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Month <u>2</u> Day <u>14</u> Year <u>1925</u>	9. AGE (In years last birthday) <u>82</u> yrs.	10. IF UNDER 1 YEAR Months <u>8</u> Days <u>2</u>	11. IF UNDER 24 HRS. Hours <u>2</u> Min. <u>0</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Interior Decorator</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self employed</u>		11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>					
13. FATHER'S NAME <u>Theodore Fuhrman</u>		14. MOTHER'S MAIDEN NAME <u>Caroline Hopper</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give year or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>220-09-6630</u>		17. INFORMANT Address <u>Hosp. Records</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>401 Pulmonary Emboli. Pulmonary Infarction</u> DUE TO <u>MURAZ Thrombi Rt Atrium</u> Conditions, if any, which gave rise to immediate cause (b) <u>Pulmonary Embolism</u> (c) <u>Congestive Heart Failure - Atrial Fibrillation</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a) <u>Arteriosclerotic Heart Disease with Atrial Fibrillation</u>								INTERVAL BETWEEN ONSET AND DEATH <u>days</u>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18)		20c. TIME OF INJURY Hour <u>19</u> Month, Day, Year		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>11-3-1967</u> to <u>11-6-1967</u> , that (I) (we) last saw the deceased alive on <u>11-6-1967</u> , and that death occurred at <u>11-6-1967</u> M, from the causes and on the date stated above.								22a. SIGNATURE <u>I Y. Cordoba</u> M.D.		22b. DATE <u>11/6/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>I Y. CORDOBA</u>		22d. ADDRESS <u>BALTO. Co. Gen. Hosp</u>		22e. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22f. ADDRESS <u>BALTO. Co. Gen. Hosp</u>		22g. DATE <u>11/6/67</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>11-9-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Lorraine Park Cem.</u>		23d. LOCATION (City, town or county) (State) <u>Underhill Rd BALTO Co</u>		23e. REC'D BY REGISTRAR <u>NOV 8 1967</u>		23f. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
14852											
1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <i>Md</i> b. COUNTY <i>Carroll</i>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Swains Mills</i>				c. LENGTH OF STAY IN 1b <i>2 mos.</i>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Seafordville</i>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>27 Pleasant Hill Road</i>						d. STREET ADDRESS			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <i>George</i> Middle <i>A.</i> Last <i>Gallion, Sr.</i>						4. DATE OF DEATH Month <i>Nov.</i> Day <i>27</i> Year <i>1967</i>					
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Jan. 31, 1880</i>		9. AGE (If years last birthday) <i>87</i> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Stationman</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>Montgomery Avenue</i>		11. BIRTHPLACE (County & State, or foreign country) <i>Md</i>			12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		
13. FATHER'S NAME <i>George H. Gallion</i>						14. MOTHER'S MAIDEN NAME <i>Annie Bushey</i>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>				16. SOCIAL SECURITY NO. <i>212-26-5428</i>		17. INFORMANT <i>Mrs Beauge Gallion - above</i>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Uremia</i> DUE TO (b) <i>Adenocarcinoma sigmoid colon</i> DUE TO (c) <i></i>										INTERVAL BETWEEN ONSET AND DEATH <i>48 hrs.</i> <i>3 1/2 months</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <i>October 9, 1967</i> , to <i>Nov. 27, 67</i> , that (I) (we) last saw the deceased alive on <i>Nov. 20</i> 1967, and that death occurred at <i>3A</i> M., from the causes and on the date stated above.											
22a. SIGNATURE <i>Martin E. Strobel</i>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <i>11-27-67</i>			
22c. PHYSICIAN'S NAME (Type) <i>Martin E. Strobel, M.D.</i>						22d. ADDRESS <i>59 Hanover Rd. Reisterstown, Md.</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>				23b. DATE THEREOF <i>11-29-67</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Mt View</i>		23d. LOCATION (City, town or county) (State) <i>Alpha Howard Co. Md.</i>			
24. FUNERAL DIRECTOR <i>Arthur H. Haight</i>				ADDRESS <i>Seafordville, Md.</i>		25a. REC'D BY REGISTRAR <i>Charles Judge</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		DATE <i>NOV 30 1967</i>	



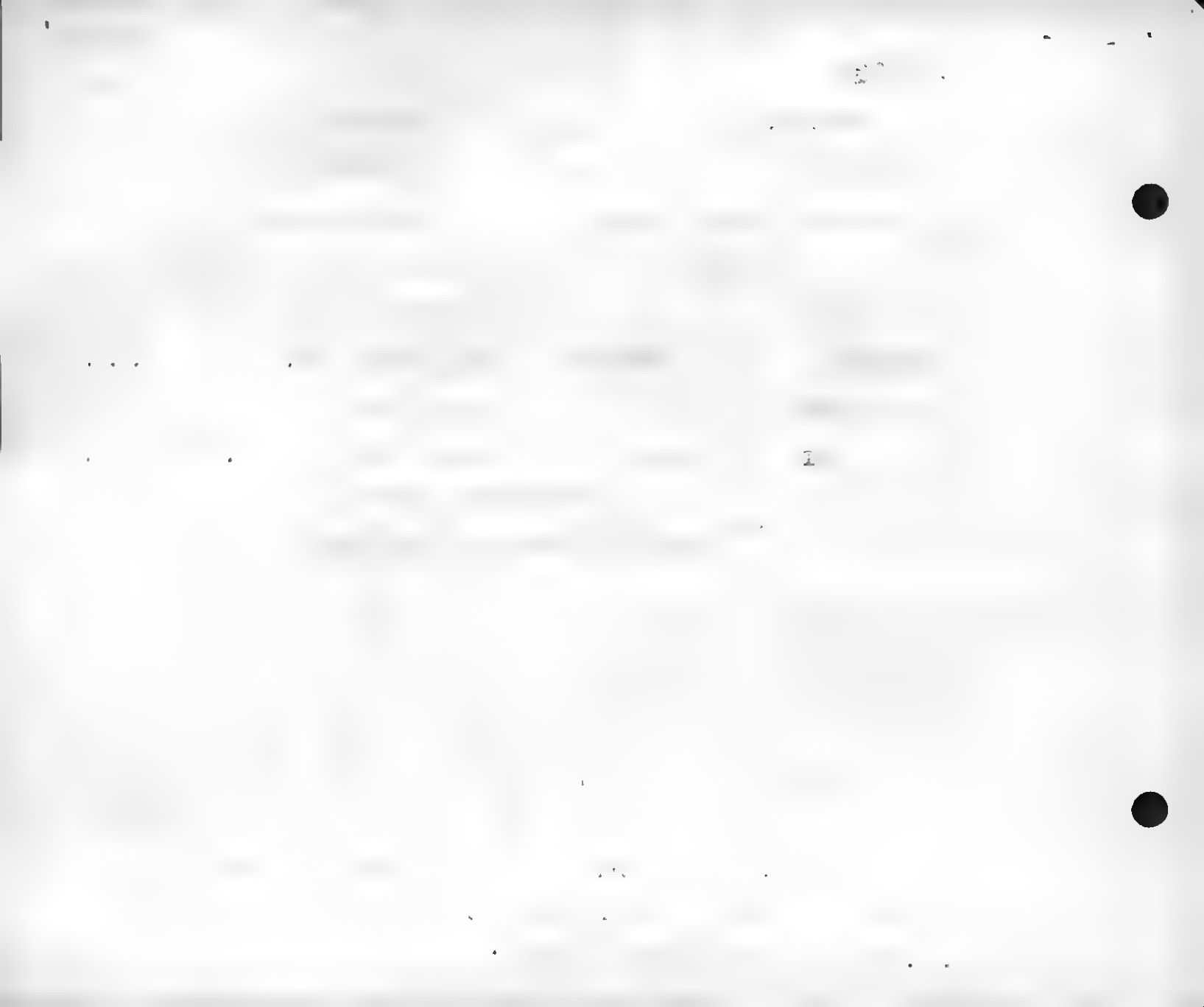


CERTIFICATE OF DEATH

14953

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>12711</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>		c. LENGTH OF STAY IN 1b <b>28 DAYS</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>VETERANS ADMINISTRATION HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>ALEXANDER</b> Middle <b>GIFFORD</b> Last <b>GIFFORD</b>		4. DATE OF DEATH Month <b>NOVEMBER</b> Day <b>6</b> Year <b>1967</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10/27/95</b>
9. AGE (in years last birthday) <b>72</b> yrs		10. UNDER 1 YEAR Months <b>0</b> Days <b>0</b>	11. UNDER 24 HRS Hours <b>0</b> Min <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>REPORTER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>NEWSPAPER</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>GREENFIELD, MASS.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>RALPH GIFFORD</b>		14. MOTHER'S MAIDEN NAME <b>SARA PARSONS</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>YES WWII</b>		16. SOCIAL SECURITY NO. <b>212 07 79 31</b>	
17. INFORMANT <b>CLINICAL RECORDS, VAH, FT. HOWARD, MD.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>ARTERIOSCLEROTIC HEART DISEASE</b> <b>4200</b> Conditions if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>PERICARDIAL EFFUSION, HEMORRHAGIC</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>Years</b> <b>Unknown</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <b>Dr.</b> (this hospital) attended the deceased from <b>OCT 9</b> , 19 <b>67</b> to <b>NOV 6</b> , 19 <b>67</b> , that <b>(*)</b> (we) last saw the deceased alive on <b>NOV 6</b> , 19 <b>67</b> , and that death occurred at <b>5:30A</b> M. from causes and on the date stated above.			
22a. SIGNATURE <b>J. D. Talbert</b>		22b. DATE SIGNED <b>11/6/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>JOHN D. TALBERT, M.D.</b>		22d. ADDRESS <b>VA Hospital, Fort Howard, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <b>11-8-67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>BALTO. NATIONAL CEMETERY</b>	23d. LOCATION (City or Town) (County) (State) <b>BALTIMORE, MARYLAND</b>
24. FUNERAL DIRECTOR <b>Wm. E. JOHNSON</b>		25a. REC'D BY REGISTRAR <b>NOV 9 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <b>MD</b> b. COUNTY				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>GARRISON</b>			c. LENGTH OF STAY IN 1b <b>6 DAYS</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>FOXLEIGH NURSING HOME</b>					d. STREET ADDRESS <b>HAMPSHIRE HOUSE APTS. 6001 PARK HEIGHTS AVE</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>DAVID</b> Middle Last <b>GITOMER</b>					4. DATE OF DEATH Month <b>11</b> Day <b>5</b> Year <b>1967</b>				
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>9/28/95</b>		9. AGE (in years last birthday) <b>72</b> yrs. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>PHARMACEUTICAL PROPRIETOR</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>REALTOR</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Russia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JOSEPH GITOMER</b>					14. MOTHER'S MAIDEN NAME <b>ANNA KAHN</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <b>MRS. DORA GITOMER, 6001 PARK HEIGHTS AVE. #15</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of the lung</b> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									INTERVAL BETWEEN ONSET AND DEATH <b>18 mcs.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <b>Sep. 1966</b> , to <b>Nov. 5, 1967</b> , that (I) (we) last saw the deceased alive on <b>Nov. 3, 1967</b> , and that death occurred at <b>4 AM</b> , from the causes and on the date stated above.									
22a. SIGNATURE <b>Marvin Goldstein</b>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>Nov. 5, 1967</b>		
22c. PHYSICIAN'S NAME (Type) <b>MARVIN GOLDSTEIN</b>					22d. ADDRESS <b>6001 PARK HEIGHTS AVE. - #15</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>11-6-67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>BETH TFILOH</b>			23d. LOCATION (City, town or county) (State) <b>BALTIMORE, MARYLAND</b>		
24. FUNERAL DIRECTOR <b>SOL LEVINSON &amp; BROS., INC., 6010 REISTERSTOWN RD.</b>					25a. REC'D BY REGISTRAR <b>NOV 9 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14855

CERTIFICATE OF DEATH

14860

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a COUNTY <b>Baltimore, Maryland</b> b CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <b>Catonsville, Md.</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a STATE <b>Md.</b> b COUNTY <b>Balt.</b>	
c. LENGTH OF STAY IN <b>1 mos. 6 days</b>		c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <b>Baltimore</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Spring Grove State Hosp.</b>		d. STREET ADDRESS <b>1716 Glenkeith Blvd. Balt. Md.</b>	
3. NAME OF DECEASED (Type or print) <b>Henry Clay Glover</b>		4. DATE OF DEATH Month <b>November</b> Day <b>26</b> Year <b>19 67</b>	
5. SEX <b>male</b>	6. PHENOTYPE RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2-9-76</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>salesman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Hardware</b>	9. AGE (In years last birthday) <b>91 yrs</b>
11. BIRTHPLACE (County & State or foreign country) <b>Baltimore, md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <del>unknown</del> <b>Wm.H. Glover</b>		14. MOTHER'S MAIDEN NAME <del>Margaret Thumblitt</del> <b>Margaret Thumblitt</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>175-09-6454</b>	
17. INFORMANT <b>Spring Grove Records</b>		Address <b>Catonsville</b>	
18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Myocardian Infarction</b> DUE TO (c) <b>Gererelixed artierisclerotic (heart disease)</b>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>10-20</b> , 19 <b>67</b> to <b>11-26</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>11-26</b> , 19 <b>67</b> , and that death occurred at <b>1:45</b> M, from causes and on the date stated above.			
22a. SIGNATURE <i>Evelio A. Felipe</i> MD		22b. DATE SIGNED <b>11-26 67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Evelio A. Felipe M.D.</b>		22d. ADDRESS <b>Spring Grove State Hosp.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>11-29-67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park</b>	23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Maryland</b>
24. FUNERAL DIRECTOR <b>Wm.E. Johnson 8521 Loch Raven Blvd. 21204</b>		25a. REC'D BY REGISTRAR DATE <b>NOV 29 1967</b>	
		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM-3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14956

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14961

1 PLACE OF DEATH a COUNTY <u>BALTIMORE</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE <u>Maryland</u> b COUNTY <u>Baltimore</u>	
b CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>Kingsville Md.</u>		c LENGTH OF STAY IN It <u>84 yrs</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>1152 Cent Cheryl Ave Belair Rd</u>		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <u>Henry Goeb</u>		4 DATE OF DEATH Month <u>11</u> Day <u>30</u> Year <u>1967</u>	
5 SEX <u>M</u>	6 COLOR OR RACE <u>W</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>21 July 06</u>
9 AGE (In years last birthday) <u>61</u> yrs		F UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Printer</u>		10b KIND OF BUSINESS OR INDUSTRY <u>Self-employed</u>	
11 BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13 FATHER'S NAME <u>George Goeb</u>		14 MOTHER'S MAIDEN NAME <u>Louisa M Engelhardt</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16 SOCIAL SECURITY NO <u>212-05-2779</u>	
17 INFORMANT <u>Mrs Ruth W. Goeb Cheryl Avenue Kingsville</u>		Address <u>21087</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY <u>4221</u> IMMEDIATE CAUSE (a) <u>Atherosclerotic Cardiovascular Disease</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH _____	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19 WAS AN AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John C. Hyle</u> M.D.		22. DATE SIGNED <u>11-30-67</u>	
EXAMINER'S NAME (Type) <u>JOHN C. HYLE</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town or county) <u>2227 Belair Rd</u>	
23a BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	23b DATE THEREOF <u>12-4-1967</u>	23c NAME OF CEMETERY OR CREMATORY <u>Belair Memorial Cemetery</u>	23d LOCATION (City or town) (County) (State) <u>Bel Air, Harford Md.</u>
24 FUNERAL DIRECTOR <u>Laws Funeral Home 7701 Belair Rd</u>		25a REC'D BY REGISTRAR <u>Charles Judge</u> 25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
DATE <u>DEC 4 1967</u>			





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, and return them to the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14957

CERTIFICATE OF DEATH

14962

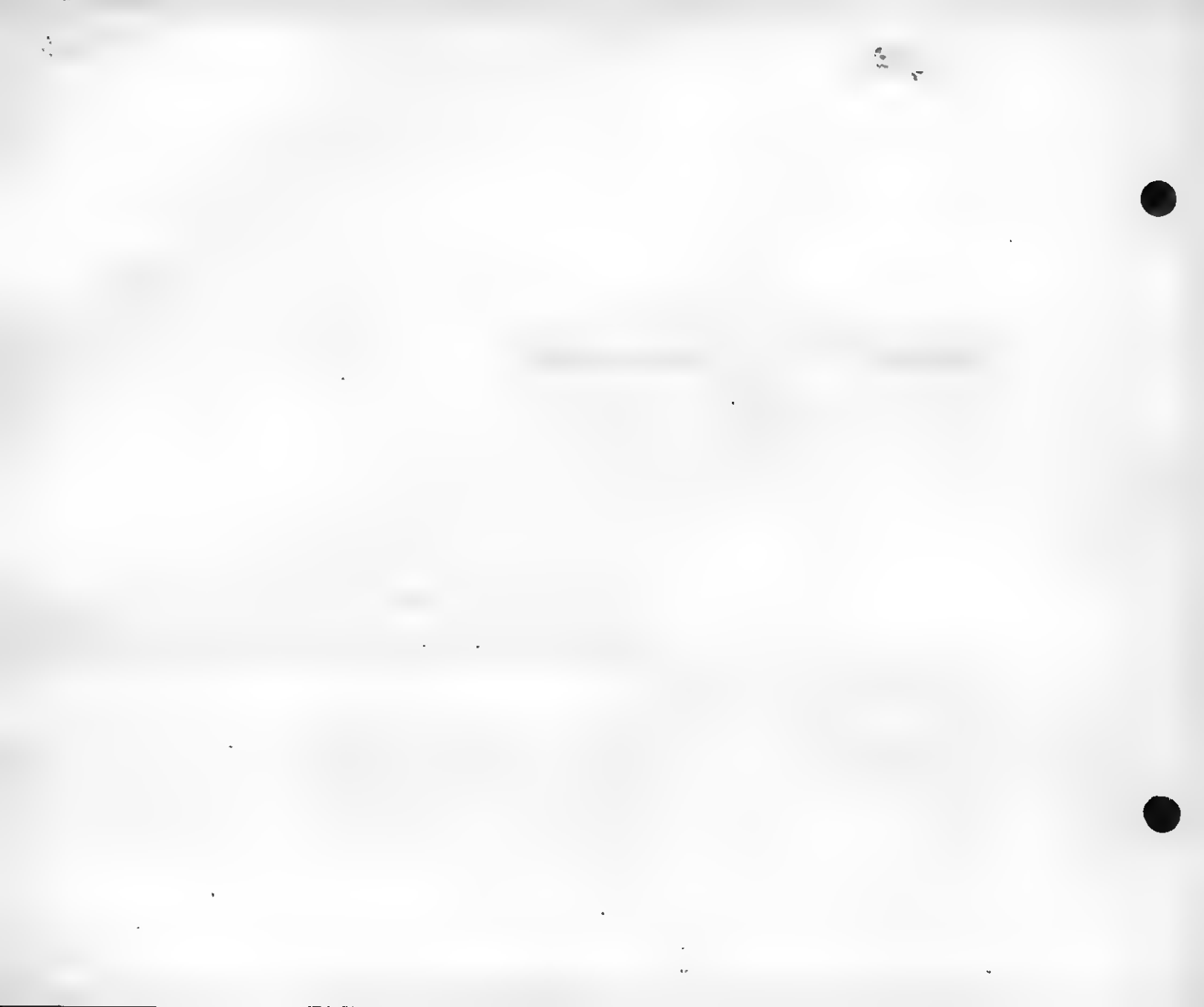
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
c. LENGTH OF STAY IN 1b <b>9 yr. 9 mo. 7 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>SPRING GROVE STATE HOSPITAL</b>		d. STREET ADDRESS <b>784 West Hamburg Street</b>	
3. NAME OF DECEASED (Type or print) <b>George H. Goetz</b>		4. DATE OF DEATH Month <b>November</b> Day <b>12</b> Year <b>19 67</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5/16/75</b>
9. AGE (In years lost birthday) <b>92</b> yrs.		10. IF UNDER 1 YEAR Months <b>12</b> Days <b>19</b> Hours <b>67</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>unknown</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>unknown</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Louis Goetz</b>		14. MOTHER'S MAIDEN NAME <b>Georgian (Unknown)</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <b>217-16-7786-1</b>	
17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY <b>491X Bilateral bronchopneumonia</b> IMMEDIATE CAUSE (a) <b>491X</b> DUE TO (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <b>W</b> (this hospital) attended the deceased from <b>2/5/58</b> , 19 <b>58</b> , to <b>11/12</b> , 19 <b>67</b> , that <b>W</b> (we) last saw the deceased alive on <b>11/12</b> , 19 <b>67</b> , and that death occurred at <b>10:15 p.m.</b> from causes and on the date stated above			
22a. SIGNATURE <b>Anthony J. Young, M.D.</b>		22b. DATE SIGNED <b>11-13-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Anthony J. Young, M.D.</b>		22d. ADDRESS <b>Spring Grove State Hospital Baltimore, Maryland 21228</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>11-15-1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Glen Haven Mem. Park</b>	23d. LOCATION (City or Town) (County) (State) <b>Glen Burnie, Md</b>
24. FUNERAL DIRECTOR <b>Wm. Cook-Brooks, Inc., 1217 St. Paul St. Balto., Md</b>		25a. REC'D BY REGISTRAR <b>NOV 16 1967</b>	25b. REGISTRAR'S SIGNATURE <b>Wm. Cook-Brooks, Inc.</b>



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
4052										
CERTIFICATE OF DEATH										
1463										
1. PLACE OF DEATH a. COUNTY Baltimore					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Md.					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Towson					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Sykesville P.O. Rt 1 Box 175					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Greater Baltimore Medical Center					e. STREET ADDRESS Oakland Mills Rd					
3. NAME OF DECEASED (Type or print) First Middle Last Hilda Gordon					4. DATE OF DEATH Month Day Year Nov 6 1967					
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8/17/02		9. AGE (in years last birthday) 65 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nursing					10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Harville Koon					14. MOTHER'S MAIDEN NAME Minnie Hindley					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No					16. SOCIAL SECURITY NO. 214-03-3702		17. INFORMANT Patient's chart			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Confluent broncho-pneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pathological fracture left leg - Carcinoma of thyroid (by history)										
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 10/5, 1967, to 11/6, 1967, that (I) (we) last saw the deceased alive on 11/6, 1967, and that death occurred at 2:20 P.M. from the causes and on the date stated above.										
22a. SIGNATURE Rudiger Breiteneker					22b. DATE SIGNED 11/6/67					
22c. PHYSICIAN'S NAME (Type) Rudiger Breiteneker, M.D.					22d. ADDRESS 6701 N. Charles Street					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF 11-8-67		23c. NAME OF CEMETERY OR CREMATORY Lakeside Memorial Cemetery		23d. LOCATION (City, town or county) (State) Carroll Co Md				
24. FUNERAL DIRECTOR Loring Byers, 8728 Liberty Rd					25a. REC'D BY REGISTRAR DATE NOV 8 1967					
					25b. REGISTRAR'S SIGNATURE Charles Judge					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1, 2, and 3 and 4. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14958

14964

1 PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>		c. LENGTH OF STAY IN 1b <b>Rodgers Forge</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>St. Joseph Hospital</b>		d STREET ADDRESS <b>147 Stevenson Lane</b>	
3 NAME OF DECEASED (Type or print) <b>Charles P Gorsuch</b>		4 DATE OF DEATH Month <b>11</b> Day <b>17</b> Year <b>1967</b>	
5 SEX <b>Male</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>Oct. 26, 1908</b>
9 AGE (In years lost birthday) <b>59 yrs</b>		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS Hours Min.
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk Ret.</b>		10b KIND OF BUSINESS OR INDUSTRY <b>Railroad</b>	
11 BIRTHPLACE (County & State, or foreign country) <b>Baltimore, Md.</b>		12 CITIZEN OF WHAT COUNTRY?	
13 FATHER'S NAME <b>Pinkney S. Gorsuch</b>		14 MOTHER'S MAIDEN NAME <b>Clara F. Saunders</b>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16 SOCIAL SECURITY NO <b>217-05-3063</b>	
17 INFORMANT <b>Mrs. Mary C. Gorsuch</b>		Address <b>147 Stevenson Lane</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Coronary Occlusion</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Atherosclerotic Cardiovascular Disease</b> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>Feb.</b> , 19 <b>60</b> , to <b>Nov 17</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>Nov. 15</b> , 19 <b>67</b> , and that death occurred at <b>9 A</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>Dr. S.J. Venable Jr.</b>		22b. DATE SIGNED <b>Nov. 18, 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. S.J. Venable Jr.</b>		22d. ADDRESS <b>7215 York Rd. Baltimore MD.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>11/21, 1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral Cemt.</b>	23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Maryland</b>
24. FUNERAL DIRECTOR <b>Mitchell-Wiedefeld Home</b>		25a. REC'D BY REGISTRAR DATE <b>NOV 24 1967</b>	
ADDRESS <b>65po York Rd. Balto., Md. 21212</b>		25b. REGISTRAR'S SIGNATURE <b>William J. Judge</b>	

MEDICAL CERTIFICATION



# FOR STATE HEALTH DEPT.

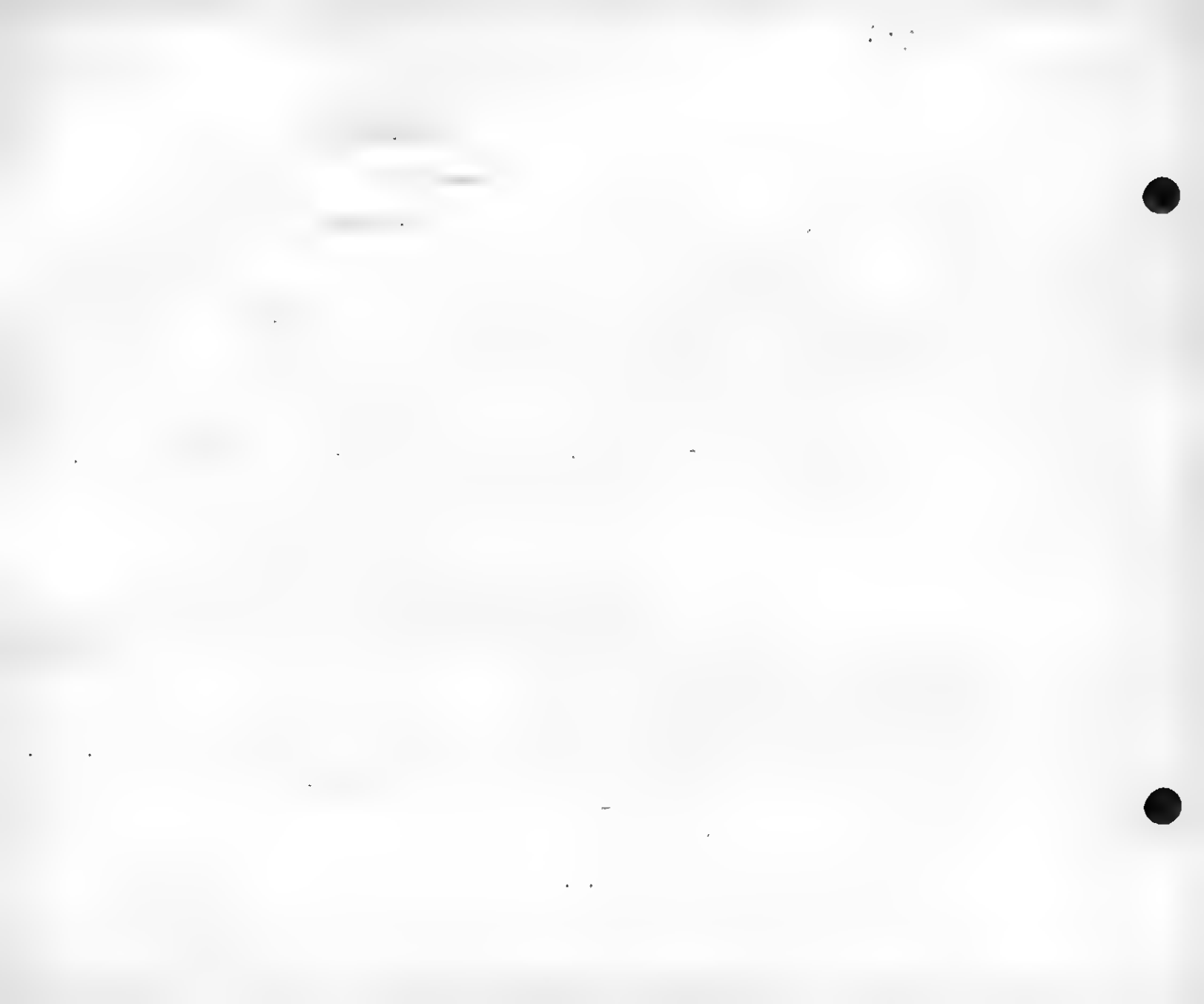
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 10-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 20b-7 Dr. F. F. Wilson, M.D. 11-15-67

MEDICAL CERTIFICATION

1 PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fullerton</b>		c. LENGTH OF STAY IN 1b <b>None</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>8324 Belair Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <b>EUGENE JOSEPH GRANT</b>		4 DATE OF DEATH <b>November 11 1967</b>	
5 SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3-7-1949</b>
9 AGE (In years last birthday) <b>18</b> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LABORER</b>	
11 BIRTHPLACE (State or foreign country) <b>SAXE, VIRGINIA</b>		12 CITIZEN OF WHAT COUNTRY?	
13 FATHER'S NAME <b>JOSEPH GRANT</b>		14 MOTHER'S MAIDEN NAME <b>MARY SCOTT</b>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16 SOCIAL SECURITY NO <b>228-72-7929</b>	
17 INFORMANT <b>Mrs. Mary Scott</b>		Address <b>4961 Stiles St. Phil</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: <b>823.4</b> IMMEDIATE CAUSE (a) <b>Multiple traumatic injuries</b> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <b>in auto</b> <b>Subject apparently struck mailbox</b>	
20c. TIME OF INJURY Month, Day, Year <b>7:07xx 11 11 1967</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> <b>at work of work</b>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Street</b>	20f. (City or town) (County) (State) <b>Fullerton Balto. Md.</b>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Edward F. Wilson</b>		22. DATE SIGNED <b>November 11, 1967</b>	
EXAMINER'S NAME (Type) <b>Edward F. Wilson, M.D.</b>		Address (Street, city, town, or county) <b>Novmeber 11, 1967</b>	
23a. BURIAL CREMATION, ETC. (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>11-16-67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>PINEY GROVE CH. CEM.</b>	23d. LOCATION (City or Town) (County) (State) <b>CHARLOTTE COURT HOUSE VA.</b>
24. FUNERAL DIRECTOR <b>MORTON &amp; DYETT F.H.</b>		ADDRESS <b>1701 Laurens Street</b>	
25a. REC'D BY REGISTRAR <b>NOV 13 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	





## CERTIFICATE OF DEATH

1 PLACE OF DEATH a COUNTY <b>Baltimore</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if not in residence before admission) a STATE <b>Maryland</b> b COUNTY <b>Baltimore</b>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c LENGTH OF STAY IN 1b	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>245 Meadowvale Road</b>		e STREET ADDRESS <b>245 Meadowvale Road</b>	
3 NAME OF DECEASED (Type or print) First <b>Russell</b> Middle <b>L.</b> Last <b>Grau Sr.</b>		4 DATE OF DEATH Month <b>Nov.</b> Day <b>18,</b> Year <b>1967</b>	
5 SEX <b>male</b>	6 COLOR OR RACE <b>white</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>Sept. 8, 1896</b>
9 AGE (In years last birthday) <b>71 yrs</b>		10 IF UNDER 1 YEAR Months <b>7</b> Days <b>1</b> Hours <b>19</b> Min.	
11 USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Office clerk</b>		12 INDUSTRY <b>engineering</b>	
13. FATHER'S NAME <b>Frank S. Grau</b>		14. MOTHER'S MAIDEN NAME <b>Laura Peters</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b> (If yes give year or dates of service) <b>W.W.I</b>		16. SOCIAL SECURITY NO. <b>173-05-0120-A</b>	
17. INFORMANT <b>Russell L. Grau Jr.</b>		Address <b>245 Meadowvale Rd. #4</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Coronary Occlusion</b> DUE TO (b) <b>ARTERIOsclerotic Cardiovascular Disease</b> DUE TO (c) <b>4 yrs</b>		INTERVAL BETWEEN ONSET AND DEATH <b>4 yrs</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 1b)	
20c TIME OF INJURY Month, Day, Year Hour <b>19</b> o.m. p.m.	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>April 8, 1966</b> to <b>Nov 18, 1967</b> , that (I) (we) last saw the deceased alive on <b>April 8, 1966</b> , and that death occurred at <b>2:10 P.M.</b> from causes and on the date stated above			
22a SIGNATURE <b>Dr. S. J. Venable</b>		22b DATE SIGNED <b>11-20-67</b>	
22c PHYSICIAN'S NAME (Type) <b>Dr. S. J. Venable</b>		22d ADDRESS <b>7215 York Road - Baltimore 40</b>	
23a BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b DATE THEREOF <b>11/22/67</b>	23c NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>	23d LOCATION (City or town) (County) (State) <b>Arlington, Va.</b>
24 FUNERAL DIRECTOR <b>Mitchell-Wiedefeld Home</b>		25a REC'D BY REGISTRAR <b>NOV 24 1967</b>	
ADDRESS <b>6500 York Road</b>		25b REGISTRAR'S SIGNATURE <b>[Signature]</b>	
BALTO., MD. 21212			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



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VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
Items #8 & 9 Film #0394 11/15/67											
14962 14967											
CERTIFICATE OF DEATH											
1 PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND						2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>				c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>				31-4	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>House in the Pines - Fusting Ave.</u>						d. STREET ADDRESS <u>2915 Edgewood Ave.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <u>Lillian L. Gregorius</u>						4 DATE OF DEATH Month <u>NOV.</u> Day <u>4</u> Year <u>1957</u>					
5 SEX <u>F</u>		6. COLOR OR RACE <u>Cauc.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept. 2/78</u>		9. AGE (in years last birthday) <u>87</u> yrs		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Wood</u>						14. MOTHER'S MAIDEN NAME <u>Catherine</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO		17. INFORMANT <u>Mrs. Dorothy Blake</u> <u>22 Locust Drive - 21228</u>				Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Ischemia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arteriosclerotic Cardio-Vascular Disease</u> DUE TO (c) <u>  </u>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY: Month, Day, Year Hour <u>  </u> a.m. <u>  </u> p.m. <u>  </u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>10-28, 1967</u> , to <u>11-4, 1967</u> , that (I) (we) last saw the deceased alive on <u>11-3-1967</u> , and that death occurred at <u>6 P.M.</u> from causes and on the date stated above											
22a. SIGNATURE <u>Wilmer K. Gallagher, Sr.</u>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>11-6-67</u>			
22c. PHYSICIAN'S NAME (Type) <u>Wilmer K. Gallagher, Sr.</u>						22d. ADDRESS <u>6209 Frederick Ave.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>11/7/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National Cem.</u>				23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Md.</u>			
24. FUNERAL DIRECTOR <u>Witzke F. D. - 4101 Edmondson Ave.</u>						25a. REC'D BY REGISTRAR DATE <u>NOV 8 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Wilmer K. Gallagher, Jr.</u>			



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

14963

14968

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>Md</b> b. COUNTY <b>✓</b>	
b. CITY OR TOWN (If outside corporate limits, write RJRAL and give nearest town) <b>Towson</b>		c. LENGTH OF STAY IN 1b <b>3 yrs</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Stella Maris Hospice</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Pauline First Middle Last</b> <b>Pauline Grochmal</b>		4. DATE OF DEATH <b>11/15/67</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1/26/1883</b>
9. AGE (n years last birthday) <b>84 yrs</b>		10. UNDER 1 YEAR Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Hswf</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>German</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>German</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Stanley Fisher</b>		14. MOTHER'S MAIDEN NAME <b>Catherine Jaminski</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO <b>217-48-1690</b>	
17. INFORMANT <b>Hospice records</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY <b>4330</b> IMMEDIATE CAUSE (a) <b>Cardio-Respiratory Arrest</b> DUE TO (b) <b>ASCP</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>Smoking</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>May</b> , 1964, to <b>Nov.</b> , 1967, that (I) (we) last saw the deceased alive on <b>11/16/67</b> , 19, and that death occurred at <b>10:58 PM</b> , from causes and on the date stated above			
22a. SIGNATURE <b>Robert J. Mahon</b>		22b. DATE SIGNED <b>11/15/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Robert J. Mahon, M.D.</b>		22d. ADDRESS <b>204 E. Joppa Rd., Towson</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>11-18-67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral Cem.</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore MARYLAND</b>	
24. FUNERAL DIRECTOR <b>Wm. Cook-Brooks Towson Inc.</b>		25a. REC'D BY REGISTRAR <b>1050 YORK Rd. Towson, Md. 21204</b>	
25b. REGISTRAR'S SIGNATURE <b>John A. Jones</b>		DATE <b>NOV 20 1967</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
14964					14969				
1 PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)				
a. COUNTY		Baltimore			a. STATE		Md.		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Baltimore			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Baltimore		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)					e. STREET ADDRESS			f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Greater Baltimore Medical Center					308 S. Clinton St.				
3 NAME OF DECEASED (Type or print)					4 DATE OF DEATH				
First Middle Last ERNEST J. GRONBERG, JR.					Month Day Year Nov. 16, 19 67				
5 SEX	6 COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8 DATE OF BIRTH	9 AGE (in years last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS.		
male	white	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	7/21/1911	56 yrs.	Months	Days	Hours	Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (County & State or foreign country)		12 CITIZEN OF WHAT COUNTRY?			
Shelter Foreman		Glidden Co.		Baltimore, Md.					
13. FATHER'S NAME					14 MOTHER'S MAIDEN NAME				
Ernest J. Gronberg					Anna Hoomess				
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16 SOCIAL SECURITY NO.		17. INFORMANT Address					
yes Army WW 2				Dorthea Ey, sister, 2921 Putty Hill Av 21234					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									INTERVA. BETWEEN ONSET AND DEATH
PART DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 5210 HEMORRAGE FROM ESOPHOGEAL VARICES									11-16-67
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CIRRHOSIS OF LIVER									?
(c)									
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
NONE					NONE				
20c. TIME OF INJURY Month, Day, Year		20d. INJURY OCCURRED		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County) (State)	
Hour a.m. p.m. NONE 19		While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		NONE		NONE			
21 I certify that (I) (this hospital) attended the deceased from 10-25-1967 to 11-16-1967 that (I) (we) last saw the deceased alive on 11-3-67 19, and that death occurred at 9:00 P.M. from causes and on the date stated above.									
22a. SIGNATURE					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED		
E.G. Schimunek					M.D.		11-17-67		
22c. PHYSICIAN'S NAME (Type)					22d. ADDRESS				
Dr. Emmanuel Schimunek					342 S. East Avenue				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		11/20/67		Baltimore Nat. Cem.		Baltimore, Md.			
24. FUNERAL DIRECTOR ADDRESS					25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
Schimunek Funeral Home, Inc. 3331 Brehms Lane					DATE NOV 20 1967		Charles Judge		





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VR A15 (4)  
25M 1/67

14965

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14870

1 PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Garrison</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore 15, Md.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Foxleigh Nursing Home</u>		d. STREET ADDRESS <u>6714 Brighton Ave.</u>	
3 NAME OF DECEASED (Type or print) First <u>Lillian</u> Middle <u>McCree</u> Last <u>Grove</u>		4 DATE OF DEATH Month <u>Nov.</u> Day <u>20</u> Year <u>1967</u>	
5 SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>July 15, 1899</u>
9 AGE (In years lost birthday) <u>68</u> yrs		IF UNDER 1 YEAR Months <u>1</u> Days <u>5</u> Hours <u>17</u> Min. <u>00</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Nursing Aid</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Rooming Nursing Home</u>	
11 BIRTHPLACE (County & State, or foreign country) <u>Denver, Colorado</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Philip C. Johnson</u>		14. MOTHER'S MAIDEN NAME <u>unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16 SOCIAL SECURITY NO <u>221-01-2631D</u>	
17 INFORMANT <u>Mr Donald W. Grove, 6714 Brighton Ave.</u>		Address <u>Baltimore 15, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Carcinoma of the cervix</u> 171X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____		INTERVAL BETWEEN DEATH AND DEATH <u>171X yrs</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)	
20c TIME OF INJURY Month, Day, Year Hour <u>19</u> a.m. <u>19</u> p.m.		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>9 July</u> , 19 <u>67</u> , to <u>20 Nov</u> , 19 <u>67</u> , that (I) (we) saw the deceased alive on <u>1 Nov</u> , 19 <u>67</u> , and that death occurred at <u>6P</u> M, from causes and on the date stated above			
22a. SIGNATURE <u>M. H. Davis</u>		22b. DATE SIGNED <u>23 Nov 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>MARVIN H. DAVIS</u>		22d. ADDRESS <u>6512 Liberty Rd Bldg Ht 21207</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		23b. DATE THEREOF <u>Nov. 24, 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National Cemetery Baltimore, Md.</u>		23d. LOCATION (City or Town) (County) (State)	
24. FUNERAL DIRECTOR <u>Frank H. Newell, 1100 N. Charles St.</u>		25a. REC'D BY REGISTRAR <u>NOV 27 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12966

14971

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>rural Baltimore</b> c. LENGTH OF STAY IN 1b <b>rural Baltimore</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>3609 Sussex Road</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore Co.</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>rural Baltimore</b> d. STREET ADDRESS <b>3609 Sussex Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Dominick J. Gugliuzza</b>		4. DATE OF DEATH Month <b>Nov.</b> Day <b>25</b> Year <b>1967</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 11, 1897</b>
9. AGE (In years last birthday) <b>70</b> yrs.		10. IF UNDER 1 YEAR Months <b>7</b> Days <b>10</b> Hours <b>10</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Barber</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Barber</b>	
11. BIRTHPLACE (County & State or foreign country) <b>Sicily</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Saverio Gugliuzza</b>		14. MOTHER'S MAIDEN NAME <b>Carmella Fideli</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>yes WW 1</b>		16. SOCIAL SECURITY NO. <b>213-14-4128</b>	
17. INFORMANT <b>Mrs. Minnie F. Gugliuzza</b>		Address <b>3609 Sussex Road Balto. 7 Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>acute myocardial infarct</b> DUE TO (b) <b>arteriosclerosis</b> DUE TO (c) <b>arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>2/0</b> , 19 <b>67</b> , to <b>11/27/67</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>11/23</b> , 19 <b>67</b> , and that death occurred at <b>1 PM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>Milton Schlenoff MD</b>		22b. DATE SIGNED <b>11/27/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. Milton Schlenoff</b>		22d. ADDRESS <b>6410 Windsor Mill Rd Balto 7 Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>11/28/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Maryland</b>
24. FUNERAL DIRECTOR <b>Foring Byers 8728 Liberty Rd Baltimore</b>		25a. REC'D BY REGISTRAR <b>NOV 28 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>James J. Jones</b>			



FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14972

14967

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form DM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>BALTO.</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>BALTO</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ESSEX</b>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>115 GLIDER DR.</b>		d. STREET ADDRESS <b>115 GLIDER DR.</b>	
3. NAME OF DECEASED (Type or print) <b>JAMES R. HANEY</b>		4. DATE OF DEATH <b>NOV 25 1967</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>NOV 9, 1922</b> 45 yrs
9. AGE (In years last birthday)		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUA. OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <b>BETH. STEEL</b>	
11. BIRTHPLACE (State or foreign country) <b>PA.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>MICHAEL HANEY</b>		14. MOTHER'S M.A.DEN NAME <b>BERTHA ZOLTAN</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>YES WWII</b>		16. SOCIAL SECURITY NO. <b>188-18-4915</b>	
17. INFORMANT <b>VIOLA HANEY</b>		Address <b>115 GLIDER DR.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>53. CARCINOMA of LARGE BOWEL</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Metastasis to Liver etc</b> (c)			INTERVAL BETWEEN ONSET AND DEATH <b>11 mos</b>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <b>None</b>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>M. B. Davis</b> M.D.		22. DATE SIGNED <b>11/28/67</b>	
EXAMINER'S NAME (Type) <b>M. B. DAVIS M.D. - 6800 MORRIS BLVD. BALTO.</b>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>NOV. 29 1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>BALTO. NAT.</b>	23d. LOCATION (City or Town) (County) (State) <b>BALTO. M.D.</b>
24. FUNERAL DIRECTOR <b>J.E. CONNELLY SONS</b>		25a. REC'D BY REGISTRAR <b>300 MALE</b>	
ADDRESS <b>300 MALE</b>		25b. REGISTRAR'S SIGNATURE <b>J. E. CONNELLY</b>	
DATE <b>NOV 30 1967</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VII A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14968

14973

1 PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Reisterstown</b>		c. LENGTH OF STAY IN 1b <b>2 years</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Nicodemus Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last <b>Barbara D. Hardesty</b>		4 DATE OF DEATH Month Day Year <b>Nov. 27 1967</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>Sept. 20, 1896</b>
9 AGE (In years last birthday) <b>71 yrs</b>		10 IF UNDER 1 YEAR Months Days Hours Min	11 IF UNDER 24 HRS Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Seamstress</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Tailoring</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore, Maryland</b>		12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13 FATHER'S NAME <b>Frank Dvorak</b>		14 MOTHER'S MAIDEN NAME <b>Barbara Prochaska</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO <b>212-01-3865</b>	
17. INFORMANT <b>John C. Hardesty</b>		Address <b>Nicodemus Rd., Reisterstown, Md.</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> T.S.U. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <b>Arteriosclerotic C-V Disease</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <b>27 days</b>  <b>2 yrs.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>none</b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>none 19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) ( <del>we</del> ) attended the deceased from <b>10-3-66</b> , 19 to <b>11-27-67</b> , 19, that (I) ( <del>we</del> ) last saw the deceased alive on <b>11-24-67</b> 19, and that death occurred at <b>6:30 A.M.</b> from causes and on the date stated above			
22a. SIGNATURE <b>D. D. Caples</b>		22b. DATE SIGNED <b>11-28-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>D. D. Caples, M. D.</b>		22d. ADDRESS <b>6 Hanover Rd., Reisterstown, Md. 21136</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>Nov. 30, 1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Most Holy Redeemer Cem. Baltimore, Maryland</b>	
24 FUNERAL DIRECTOR <b>H. J. Schmitt</b>		25a. REC'D BY REGISTRAR <b>NOV 29 1967</b>	
ADDRESS <b>Owings Mills, Maryland.</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	





# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14969

## CERTIFICATE OF DEATH

14974

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution on Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Chesapeake Manor Nursing Home</u>		e. STREET ADDRESS <u>2711 Taylor Avenue</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Major Francis Harris</u>		4. DATE OF DEATH Month Day Year <u>Nov. 15 19 67</u>	
5. SEX <u>male</u>	6. CO. OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 22, 1883</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Civil Engineer</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>
13. FATHER'S NAME <u>Major Gilbert Harris</u>		14. MOTHER'S MAIDEN NAME <u>Mary E. Walker</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>213-05-9894</u>	
17. INFORMANT <u>Mrs. Laura R. Harris</u>		Address <u>(Same)</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL EDEMA</u> DUE TO (b) <u>CEREBRAL THROMBOSIS - recurrent</u> DUE TO (c) <u>ARTERIO-SCLEROTIC CARDIOVASCULAR</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 YR.</u> <u>10 YR.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (1) (this hospital) attended the deceased from <u>11-12-1967</u> , to <u>11-14-1967</u> , that (2) (we) last saw the deceased alive on <u>11-14-1967</u> , and that death occurred at <u>11-14-1967</u> M., from causes and on the date stated above			
22a. SIGNATURE <u>Donald O. Wood</u>		22b. OATH SIGNED <u>11/15/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Donald O. Wood</u>		22d. ADDRESS <u>LIMANUM MD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>11/18/67.</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Lorraine Park Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Md.</u>
24. FUNERAL DIRECTOR <u>Leonard J. Ruck, Inc Baltimore, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>NOV 15 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	



CERTIFICATE OF DEATH

14930

14975

1 PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Carroll</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>	
c. LENGTH OF STAY IN TB <u>2 months</u>		d. STREET ADDRESS <u>1st Street, Sykesville Md.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Shady Nook Nursing Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <del>First</del> <u>ANNE J. HARTMAN</u> Middle Last		4 DATE OF DEATH Month <u>Nov.</u> Day <u>29</u> Year <u>1967</u>	
5 SEX <u>Female</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>Sept 18, 1886</u> 9 AGE (In years last birthday) <u>81</u> yrs
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b KIND OF BUSINESS OR INDUSTRY <u>Home</u>	11 BIRTHPLACE (County & State or foreign country) <u>Md.</u>
12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13 FATHER'S NAME <u>William Shipley</u>	
14 MOTHER'S MAIDEN NAME <u>Catherine Fowler</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> 16. SOCIAL SECURITY NO <u>—</u>	
17. INFORMANT Address <u>Mrs. H. H. Howard Ellicott City, Md.</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO (b) <u>Arterio Sclerosis - Severe</u> DUE TO (c) <u>—</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		INTERVAL BETWEEN ONSET AND DEATH <u>5 min</u> <u>Years</u>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Sept 17, 1967</u> to <u>Nov 29, 1967</u> , that (I) (we) last saw the deceased alive on <u>Nov - 28, 1967</u> , and that death occurred at <u>10:00 P.M.</u> from causes and on the date stated above.			
22a SIGNATURE <u>Wetherbee Ford</u> M.D.		22b DATE SIGNED <u>Dec 2 - 1967</u>	
22c PHYSICIAN'S NAME (Type) <u>Wetherbee Ford</u>		22d ADDRESS <u>600 Union Ave - Balt - 28</u>	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b DATE THEREOF <u>12-2-67</u>	23c NAME OF CEMETERY OR CREMATORY <u>Pine Grove</u>	23d LOCATION (City or Town) (County) (State) <u>Mt. Airy Md.</u>
24 FUNERAL DIRECTOR <u>Harry W. Haight</u>		25a REC'D BY REGISTRAR DATE <u>DEC 6 1967</u>	
ADDRESS <u>Sykesville, Md.</u>		25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (Pages 1 and 2) should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



14971

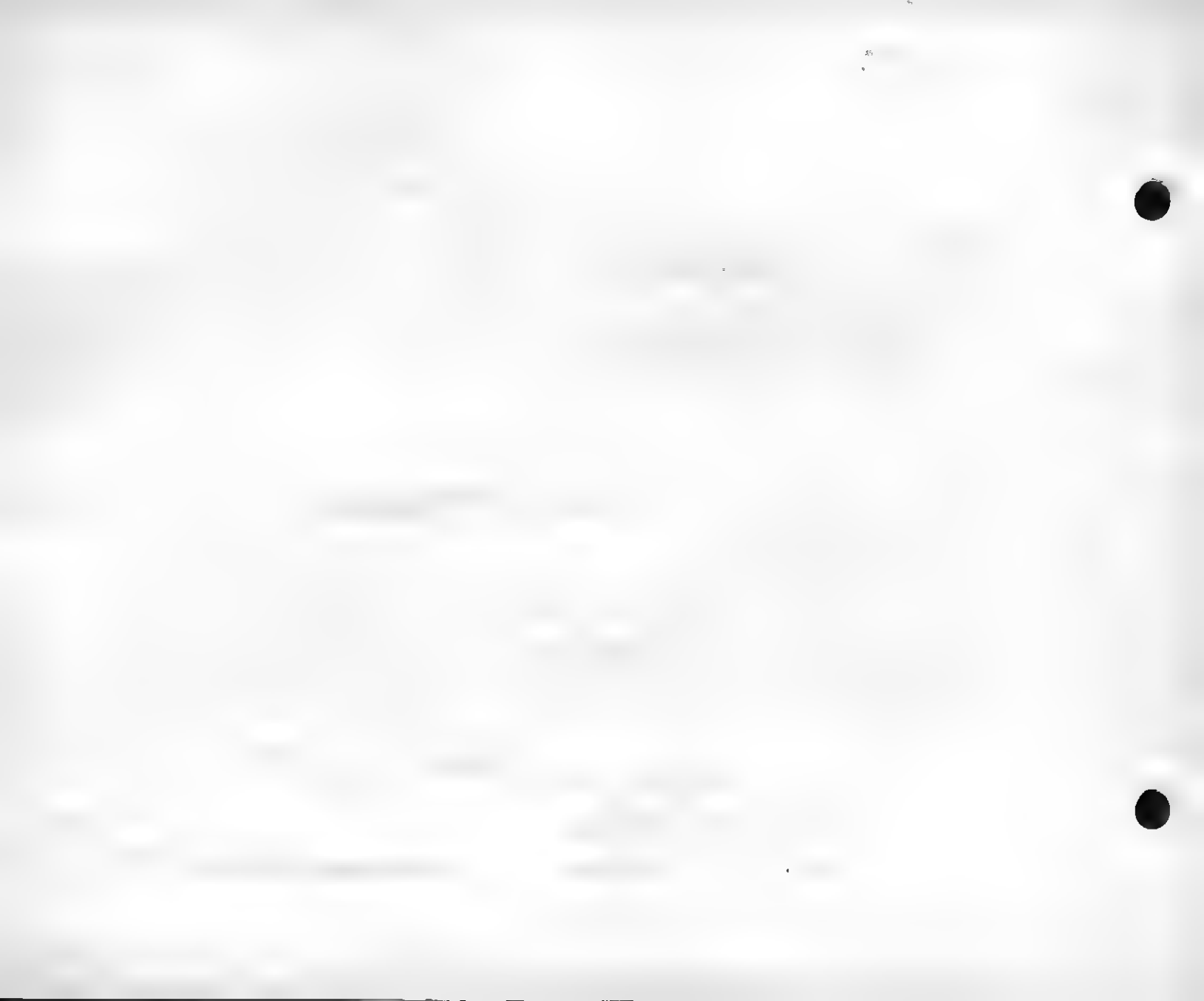
## CERTIFICATE OF DEATH

14976

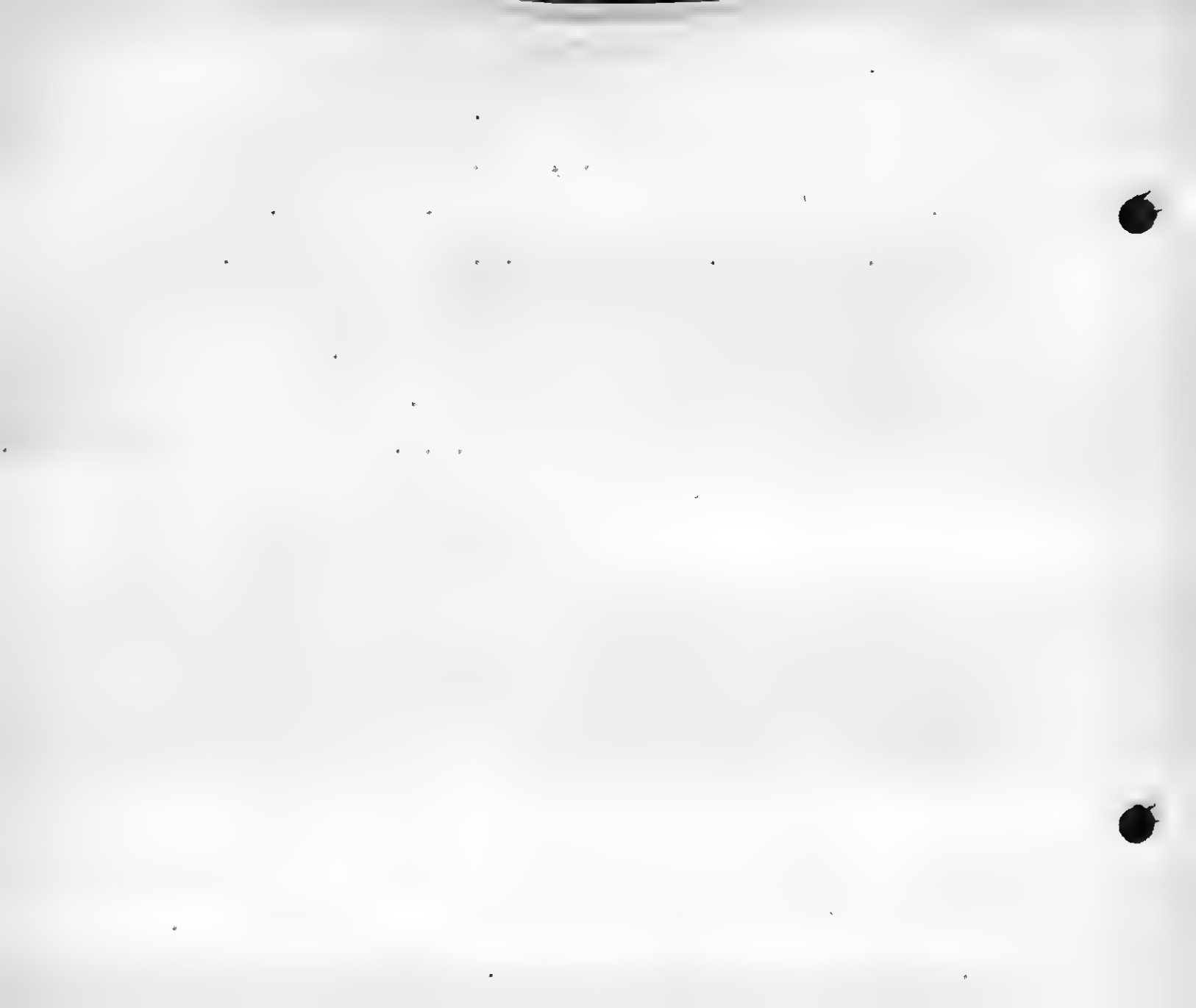
1 PLACE OF DEATH a. COUNTY <u>BALTO</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution or Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>BALTO</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ESSEX</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ESSEX</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>11 E. HICKAM</u>		d. STREET ADDRESS <u>11 E. HICKAM</u>	
3 NAME OF DECEASED (Type or print) <u>Charles W. HEISTERMAN</u>		4 DATE OF DEATH <u>NOV. 22, 1967</u>	
5 SEX <u>M</u>	6 COLOR OR RACE <u>W</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>JAN. 30 1911</u>
9 AGE (In years last birthday) <u>56</u> yrs		IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>REPAIR</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>TIRES</u>	
11 BIRTHPLACE (County & State, or foreign country) <u>MO.</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>?</u>		14. MOTHER'S MAIDEN NAME <u>?</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>UNK</u>		16 SOCIAL SECURITY NO <u>  </u>	
17 INFORMANT <u>ARMELLA HEISTERMAN</u>		Address <u>ABOVE</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>  </u> DUE TO (c) <u>  </u>			INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u>			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>  </u>		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>  </u>	
20c TIME OF INJURY Month, Day, Year Hour o.m. <u>  </u> p.m. <u>  </u> 19 <u>  </u>	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>March 4, 1961</u> to <u>Nov 15, 1967</u> , that (I) (we) last saw the deceased alive on <u>Nov 15, 1967</u> and that death occurred at <u>10 AM</u> , from causes and on the date stated above			
22a. SIGNATURE <u>Irving R Beck</u>		22b DATE SIGNED <u>11-22-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>IRVING R BECK</u>		22d. ADDRESS <u>901 Funerary Dr. Baltimore Md 21220</u>	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b DATE THEREOF <u>11/25/67</u>	23c NAME OF CEMETERY OR CREMATORY <u>LORRAINE</u>	23d LOCATION (City or Town) (County) (State) <u>BALTO. MO.</u>
24 FUNERAL DIRECTOR <u>J.G. CONNELL &amp; SONS</u>		25a REC'D BY REGISTRAR <u>300 MACE</u>	
25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>NOV 27 1967</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18									
1972									
CERTIFICATE OF DEATH									
Reg. Dist. No.									
1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> <b>MARYLAND</b>					2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>BALTIMORE</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			c. LENGTH OF STAY IN 1b <b>5 YRS.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>MT. WASHINGTON</b>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>ST. JOSEPH'S MANOR</b>					d. STREET ADDRESS <b>911 W. LAKE AVE.</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>REV. JOSEPH F. HENNESSEY S.S.J.</b>					4. DATE OF DEATH Month Day Year <b>Nov. 9 1967</b>				
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>MARCH 22, 1908</b>		9. AGE (In years lost birthday) <b>59</b> yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>R. C. PRIEST</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>CLERGYMAN</b>		11. BIRTHPLACE (State or foreign country) <b>SALEM, MASS.</b>			12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME <b>PHILIP E. HENNESSEY</b>					14. MOTHER'S MAIDEN NAME <b>JULIA E. SULLIVAN</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>VERY REV. G. F. O'DEA 1130 N. CALVERT ST.</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Diabetes Mellitus</b> <b>260X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <b>X</b>						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>X 19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <b>5/26/66</b> , 19 <b>66</b> , to <b>Nov 9</b> , 19 <b>67</b> , that I last saw the deceased alive on <b>Nov 8</b> , 19 <b>67</b> , and that death occurred at <b>1:30</b> P. M., from the causes and on the date stated above ADDRESS (Street, city or town, state) <b>1205 - N. Calvert</b> DATE SIGNED <b>Nov 10 1967</b> ACTUAL SIGNATURE <b>Hugh J. Welch</b> M.D. <b>Balt Md</b> PHYSICIAN'S NAME (Type) <b>HUGH J. WELCH</b>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>11/13/67</b>		22c. NAME OF CEMETERY OR CREMATORY <b>CATHEDRAL</b>		22d. LOCATION (City, town, or county) (State) <b>BALTIMORE, MD.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>H. W. MEARS &amp; SON 805 N. CALVERT ST.</b>					24a. REC'D BY REGISTRAR <b>NOV 14 1967</b>				
					24b. REGISTRAR'S SIGNATURE <b>Wanda Jones</b>				





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

VR A15 (M)  
25M 1/67

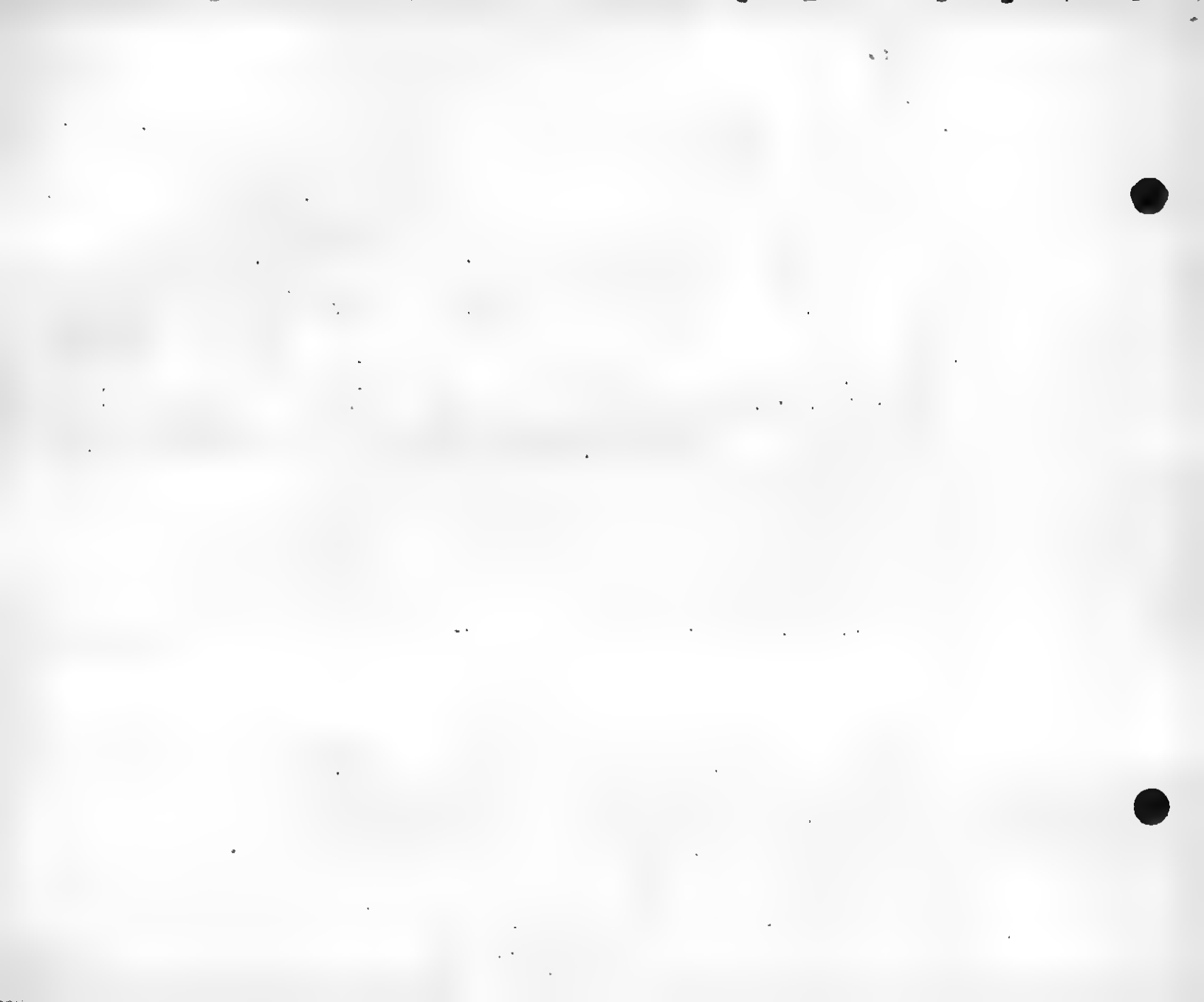
MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
14073											
CERTIFICATE OF DEATH											
14078											
1 PLACE OF DEATH a COUNTY <b>BALTIMORE</b> MARYLAND						2 USUAL RESIDENCE (Where deceased lived, f institution Residence before admission) a STATE <b>MARYLAND</b> b COUNTY <b>DORCHESTER</b> ✓					
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>				c LENGTH OF STAY IN 1b <b>82 DAYS</b>		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WINGATE</b>					
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>VETERANS ADMINISTRATION HOSPITAL</b>						d STREET ADDRESS				e RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last <b>JUNIOUS R. HENRY</b>						4 DATE OF DEATH Month Day Year <b>NOVEMBER 27 19 67</b>					
5 SEX <b>MALE</b>		6 COLOR OR RACE <b>WHITE</b>		7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH <b>JUNE 21, 1919</b>		9 AGE (In years last birthday) yrs <b>48</b>		IF UNDER 1 YEAR Months Days Hours Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>DISPATCHER</b>				10b KIND OF BUSINESS OR INDUSTRY <b>OIL COMPANY</b>		11 BIRTHPLACE (County & State, or foreign country) <b>HURLOCK, MARYLAND</b>				12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13 FATHER'S NAME <b>JOHN HENRY</b>						14 MOTHER'S MAIDEN NAME <b>KATHY JONES</b>					
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>YES WW II</b>				16 SOCIAL SECURITY NO <b>218 16 69 12</b>		17 INFORMANT Address <b>CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.</b>					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>UREMIA</b> <b>260X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <b>DIABETES MELLITUS</b> DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH <b>WEEKS</b>  <b>YEARS</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>BRONCHOPNEUMONIA &amp; ARTERIOSCLEROTIC HEART DISEASE</b>											
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)							
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc)		20f (City or town) (County) (State)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that (X) (this hospital) attended the deceased from <b>9/6/67</b> , 19 <b>67</b> , to <b>11/27/67</b> , 19 <b>67</b> , that (X) (we) last saw the deceased alive on <b>11/27/67</b> , 19 <b>67</b> , and that death occurred at <b>2:45PM</b> , from causes and on the date stated above											
22a SIGNATURE <i>Jose A. Raquel Jr. M.D.</i> M.D.						ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22b DATE SIGNED <b>11/27/67</b>			
22c PHYSICIAN'S NAME (Type) <b>JOSE A. RAQUEL, JR.</b>						22d ADDRESS <b>VAH FORT HOWARD, MARYLAND</b>					
23a BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b DATE THEREOF <b>Nov. 29, 1967</b>		23c NAME OF CEMETERY OR CREMATORY <b>DORCHESTER MEMORIAL CEM.</b>				23d LOCATION (City or Town) (County) (State) <b>CAMBRIDGE, MARYLAND</b>			
24. FUNERAL DIRECTOR <b>THOMAS FUNERAL HOME</b>						ADDRESS <b>CAMBRIDGE, MARYLAND</b>		25a REC'D BY REGISTRAR <b>NOV 30 1967</b>		25b REGISTRAR'S SIGNATURE	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 12 hours after death.

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Baltimore</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rt. 83-Parkton</u>						c. LENGTH OF STAY IN 1b <u>40 yrs.</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Rt. 83.</u>						d. STREET ADDRESS <u>Old York Rd.</u>					
3. NAME OF DECEASED (Type or print) <u>Calvin M. Hershner</u>						4. DATE OF DEATH <u>Nov. 24, 1967</u>					
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 3, 1896</u>		9. AGE (In years last birthday) <u>71</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Agent</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Insurance</u>				11. BIRTHPLACE (County & State, or foreign country) <u>Balto. Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Carlton Hershner</u>						14. MOTHER'S MAIDEN NAME <u>Edith A. Cooper</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)						16. SOCIAL SECURITY NO. <u>278-14-5472</u>					
17. INFORMANT <u>Mrs. Mary C. Kries, Parkton, Md.</u>						Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cancer of Lung</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>100%</u> DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Complete Heart Block</u>										INTERVAL BETWEEN ONSET AND DEATH <u>2 1/2 yrs</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>May 12, 1933</u> to <u>Nov. 24, 1967</u> , that (I) (we) last saw the deceased alive on <u>Nov. 17, 1967</u> , and that death occurred at <u>4:45 P.M.</u> from the causes and on the date stated above.											
22a. SIGNATURE <u>Paul D. Shaub</u>						22b. DATE SIGNED					
22c. PHYSICIAN'S NAME (Type) <u>Paul D. Shaub, M.D.</u>						22d. ADDRESS <u>Shrewsbury, Pa.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE THEREOF			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City, town or county) (State)		
<u>Burial</u>			<u>Nov. 27, 1967</u>			<u>Shrewsbury Luth. Cem.</u>			<u>Shrewsbury, Pa.</u>		
24. FUNERAL DIRECTOR <u>Isaac Kertenstein, New Freedom, Pa.</u>						25a. REC'D BY REGISTRAR <u>Charles Judge</u>					
25b. REGISTRAR'S SIGNATURE						DATE <u>NOV 28 1967</u>					



## CERTIFICATE OF DEATH

14975

14980

1 PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Parkville</b>		c. LENGTH OF STAY IN It <b>20 Years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Parkville</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>2106 Joppa Road</b>				d. STREET ADDRESS <b>2106 Joppa Road</b>			
3 NAME OF DECEASED (Type or print) First <b>Francis</b> Middle <b>X.</b> Last <b>Hickey</b>				4. DATE OF DEATH Month <b>Nov.</b> Day <b>23</b> Year <b>19 67</b>			
5 SEX <b>M</b>	6 COLOR OR RACE <b>W</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 26, 1907</b>		9 AGE (In years last birthday) <b>60 yrs</b>	IF UNDER 1 YEAR Months Days hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Engineer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>McNeill &amp; Baldwin</b>		11 BIRTHPLACE (County & State, or foreign country) <b>Penna.</b>		12 CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>James Hickey</b>				14. MOTHER'S MAIDEN NAME <b>Katy Kavamaugh</b>			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16 SOCIAL SECURITY NO. <b>163-10-156</b>		17 INFORMANT Name <b>Marie B. Hickey</b> Address <b>Same</b>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>Coronary Occlusion, Acute</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <b>Hypertensive Cardiovascular Disease</b> DUE TO (c) <b>&gt; 3 yrs.</b>						INTERVAL BETWEEN ONSET AND DEATH <b>± minutes</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c) <b>Note</b>						19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>No</b>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <b>---</b>					
20c. TIME OF INJURY Month, Day, Year hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) <b>---</b>		20f. (City or town) (County) (State) <b>---</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>14 Dec</b> , 1964, to <b>30 Sept</b> , 1967, that (I) (we) saw the deceased alive on <b>30 Sept</b> 1967, and that death occurred at <b>4:55 PM</b> , from causes and on the date stated above							
22a. SIGNATURE <b>Edward L. J. Moltz</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>24 Nov 67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Edward L. J. Moltz, M.D.</b>				22d. ADDRESS <b>7425 Harford Road (21234)</b>			
23a. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>11-27, 1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Holy Cross Cemetery</b>		23d. LOCATION (City or town) (County) (State) <b>Yeadon Penna</b>	
24 FUNERAL DIRECTOR <b>Charles F. Evans &amp; Son 8802 Harford Rd</b>				25a. REC'D BY REGISTRAR <b>NOV 27 1967</b>		25b. REGISTRAR'S SIGNATURE <b>jt mingo judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



14976

## CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Turkey Point Rural</b>		c. LENGTH OF STAY IN TB	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Box 660 Turkey Point Road</b>		d. STREET ADDRESS <b>Box 660 Turkey Point Road 21</b>	
3. NAME OF DECEASED (Type or print) <b>Ethel C. Hobbey</b>		4. DATE OF DEATH Month <b>11</b> Day <b>11</b> Year <b>19 67</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Cac</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11-25-1883</b>
9. AGE (In years lost birthday) <b>83 yrs</b>		10. IF UNDER 1 YEAR Months <b>11</b> Days <b>19</b> Hours <b>67</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Housewife</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Nova Scotia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William Hazelwood</b>		14. MOTHER'S MAIDEN NAME <b>Annie Miller</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO <b>031-26-6911</b>	
17. INFORMANT <b>Mr Harold G. Bates</b>		Address <b>660 Turkey Point Road 21221</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: <b>331X</b> IMMEDIATE CAUSE (a) <b>Cerebrovascular Accident</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) INTERVAL BETWEEN ONSET AND DEATH <b>Immediate</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>Oct 16, 1967</b> , to <b>11-11, 1967</b> , that (I) (we) last saw the deceased alive on <b>11-10, 1967</b> , and that death occurred at <b>10:30 A.M.</b> , from causes and on the date stated above			
22a. SIGNATURE <b>W. Miller M.D.</b>		22b. DATE SIGNED <b>11-13-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>W. Miller</b>		22d. ADDRESS <b>1012 Old North Point Rd.</b>	
23a. BURIAL, CREMATON, REMOVAL (Specify) <b>Cremation</b>	23b. DATE THEREOF <b>11-14-1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Greenmount Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Baltimore City Md.</b>
24. FUNERAL DIRECTOR <b>Lassahn Funeral Home</b>		ADDRESS <b>7401 Belair Rd.</b>	
25a. REC'D BY REGISTRAR <b>NOV 14 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.





14977

## CERTIFICATE OF DEATH

14982

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1 PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Essex</b>		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Essex</b>	
3 NAME OF DECEASED (Type or print) First <b>CATHERINE</b> Middle <b>B.</b> Last <b>HOCK</b>		4 DATE OF DEATH Month <b>November</b> Day <b>13</b> Year <b>1967</b>	
5 SEX <b>Female</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 5, 1895</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>House Work</b>	9 AGE (In years last birthday) <b>72</b> yrs
11. BIRTHPLACE (County & State or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Richard Hughes</b>		14. MOTHER'S MAIDEN NAME <b>Mary Baumbusch</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or Unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>213-89-4173</b>	
17. INFORMANT <b>Rita M. Wolf</b>		Address <b>1415 Old Eastern Ave Rd.,</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>260X Coronary Occlusion</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>Arteriosclerotic Cardiovascular Dis.</b> DUE TO (b) <b>Diabetes Mellitus</b> DUE TO (c) <b>10 yrs</b> <b>15 yrs</b>		INTERVAL BETWEEN ONSET AND DEATH <b>10 yrs</b> <b>15 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>1-2</b> , 19 <b>60</b> , to <b>11-13</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>11-13-67</b> , and that death occurred at <b>8:35 P.M.</b> from causes and on the date stated above.			
22a. SIGNATURE <b>G.M. Baumgardner</b>		22b. DATE SIGNED <b>11-15-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>G.M. Baumgardner</b>		22d. ADDRESS <b>8552 Philadelphia Rd., Md. 21237</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>11-16-67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Sacred Heart Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>7401 German Hill Rd., Md.</b>
24. FUNERAL DIRECTOR: <b>Charles S. Zeiler</b>		25a. REC'D BY REGISTRAR <b>DATE NOV 20 1967</b>	
ADDRESS <b>6224 Eastern Ave. Balto., 21224, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>OPH... Judge</b>	



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

10078

1433

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore 10</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>4 Over Ridge Court</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore, 10</u> d. STREET ADDRESS <u>4 Over Ridge Court</u>							
<b>3. NAME OF DECEASED</b> (Type or print) <u>WORTHINGTON ROSS HOFF</u>				<b>4. DATE OF DEATH</b> <u>NOVEMBER 16 1967</u>							
<b>5. SEX</b> <u>M</u>		<b>6. COLOR OR RACE</b> <u>W</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>Dec. 5, 1893</u>					
<b>9. AGE</b> (In years last birthday) <u>73</u> yrs.		<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Captain</u>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Riderwood, Md.</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>					
<b>13. FATHER'S NAME</b> <u>William Ross Hoff</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Annie Goldsborough</u>							
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give year or dates of service) <u>Yes WWI</u>				<b>16. SOCIAL SECURITY NO</b> <u>216-05-0454</u>							
<b>17. INFORMANT</b> <u>Mrs. Colgate S. Hoff</u>				<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMA of TONSIL</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (c) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____				<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>NONE</u>				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) (City or town) (County) (State)							
<b>20c. TIME OF INJURY</b> Hour a.m. _____ p.m. <u>19</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) (City or town) (County) (State)		<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>August 1966</u> to <u>Nov 16, 1967</u> , that (I) <del>was</del> last saw the deceased alive on <u>Nov 15, 1967</u> , and that death occurred at <u>1:00 PM</u> from the causes and on the date stated above.					
<b>22a. SIGNATURE</b> <u>A.S. Chalfant</u>				<b>22b. DATE SIGNED</b> <u>11/16/67</u>							
<b>22c. PHYSICIAN'S NAME (Type)</b> <u>Dr. A.S. CHALFANT</u>				<b>22d. ADDRESS</b> <u>6210 YORK ROAD, Baltimore Md.</u>							
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>11/18/67</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Loudon Park</u>		<b>23d. LOCATION (City, town or county) (State)</b> <u>Baltimore, Md.</u>					
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>H.W. Jenkins &amp; Sons Co.</u>				<b>25a. REC'D BY REGISTRAR</b> <u>NOV 20 1967</u>							
<u>4905 York Rd. Balto. 12, Md.</u>				<b>25b. REGISTRAR'S SIGNATURE</b> <u>[Signature]</u>							



14978

CERTIFICATE OF DEATH

14984

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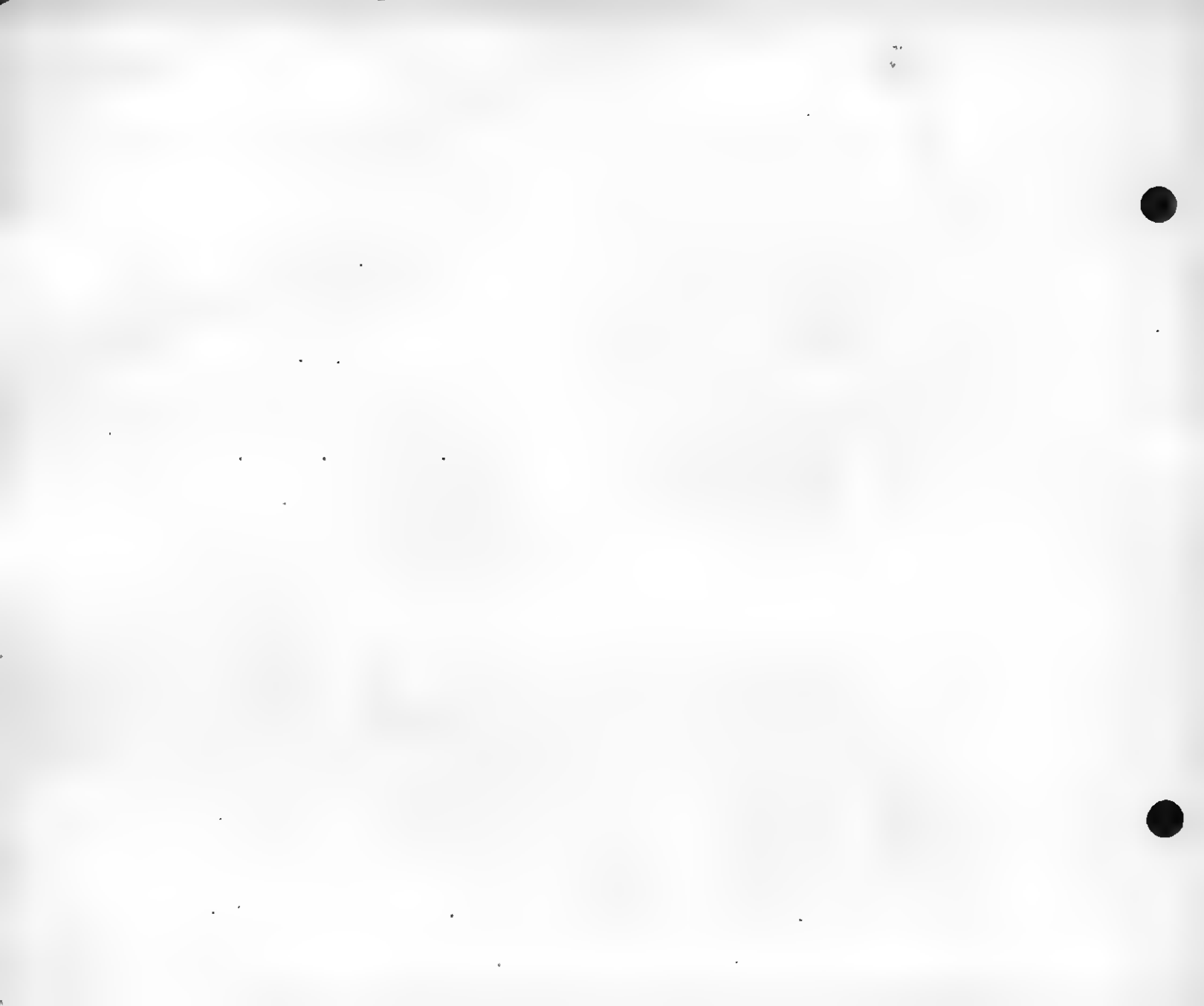
1 PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Towson</i>		c. LENGTH OF STAY IN 1b <i>Towson</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>403 Carolina Road</i>		d. STREET ADDRESS <i>403 Carolina Road</i>	
3 NAME OF DECEASED (Type or print) <i>George Howard Hoffman</i>		4 DATE OF DEATH Month <i>November</i> Day <i>17</i> Year <i>1967</i>	
5 SEX <i>Male</i>	6 COLOR OR RACE <i>White</i>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <i>December 21, 1906</i>
9 AGE (in years - last birthday) yrs <i>60</i>		10 UNDER 1 YEAR Months <i>1</i> Days <i>17</i> Hours <i>10</i> Min <i>00</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Inspector</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Calto. Co., d.</i>	
11 BIRTHPLACE (County & State or foreign country) <i>Md. land</i>		12 CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>William L. Hoffman</i>		14. MOTHER'S MAIDEN NAME <i>Anna Teragony</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO <i>None</i>	
17. INFORMANT <i>Family records</i>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Coronary Occlusion</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <i>ASVD</i> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>1 hr.</i>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>H/O Sp. cell on C. engine - totally excised</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>19</i> p.m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not While of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>2/14</i> , 19 <i>67</i> , to <i>4/10</i> , 19 <i>67</i> , that (I) (we) last saw the deceased alive on <i>2/19</i> , and that death occurred at <i>8:15</i> M., from causes and on the date stated above.			
22a. SIGNATURE <i>Robert G. Chambers</i> M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <i>Robert G. Chambers</i>		22d. ADDRESS <i>403 Carolina Road, Towson, Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>burial</i>		23b. DATE THEREOF <i>Nov. 20, 1967</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Julian Valley Memorial</i>		23d. LOCATION (City or Town) (County) (State) <i>Cockeysville, Md.</i>	
24. FUNERAL DIRECTOR <i>John Burns' Sons, Towson, Maryland</i>		25a. REC'D BY REGISTRAR DATE <i>NOV 22 1967</i>	
		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



1  
 IN HOSPITAL OR EXTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death.  
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14860  
 MARYLAND STATE DEPARTMENT OF HEALTH  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
 CERTIFICATE OF DEATH  
 14305

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b> c. LENGTH OF STAY IN 1D d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>GREATER BALTIMORE MEDICAL CENTRE</b>				2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>11 A</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Gibson Island</b> d. STREET ADDRESS <b>None</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First <b>JOHN</b> Middle <b>FRANCIS</b> Last <b>HOGAN Sr.</b>		4. DATE OF DEATH Month <b>NOVEMBER</b> Day <b>24</b> Year <b>1967</b>		5. SEX <b>M</b>		6. COLOR OR RACE <b>C</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>3-10-1886</b>		9. AGE (in years last birthday) <b>81</b> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>PHYSICIAN</b>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) <b>New Haven, Conn.</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Joseph Hogan</b>						14. MOTHER'S MAIDEN NAME <b>Harriet Maloney</b>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>220-44-1299</b>		17. INFORMANT <b>John F. Hogan Jr. Balto., Md.</b>		Address <b>5905 Meadowood Rd. XXXXX 21212</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute myocardial infarction</b> <b>7201</b> DUE TO (b) <b>Coronary athero-sclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>NO</b>												INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from _____, 19____ to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at <b>1140M</b> , from the causes and on the date stated above.													
22a. SIGNATURE <b>H. Isabelle Macpherson</b>						M.D. ATTENDING PHYS. <input type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>11-24-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>DR. TILGHMAN</b>						22d. ADDRESS <b>308 NORTH WIND RD.</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>11-28-1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral Cem.</b>				23d. LOCATION (City, town or county) (State) <b>Balto., Md.</b>			
24. FUNERAL DIRECTOR ADDRESS <b>Wm. Cook-Brooks, Inc. 1217 St. Paul St. Balto. 21202</b>						25a. REC'D BY REGISTRAR <b>NOV 27 1967</b>		25b. REGISTRAR'S SIGNATURE <b>William J. Judge</b>					





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1

14981

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14986

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY _____			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>			c. LENGTH OF STAY IN 1b <b>48 DAYS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE 21207</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>VETERANS ADMINISTRATION HOSPITAL</b>				d. STREET ADDRESS <b>3816 FERNDALE AVENUE</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>WILLIAM</b> Middle <b>H.</b> Last <b>HOLMES</b>				4. DATE OF DEATH Month <b>NOVEMBER</b> Day <b>28</b> Year <b>1967</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>NEGRO</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>3/21/90</b>	
9. AGE (In years last birthday) <b>77</b> yrs		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LABORER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>AIRCRAFT COMPANY</b>		11. BIRTHPLACE (County & State, or foreign country) <b>BALTIMORE, MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				13. FATHER'S NAME <b>WILLIAM HOLMES</b>			
14. MOTHER'S MAIDEN NAME <b>LUCIE BOLDIE</b>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>YES WW I</b>			
16. SOCIAL SECURITY NO <b>220 18 91 59</b>				17. INFORMANT Address <b>CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>CONGESTIVE HEART FAILURE</b> DUE TO (b) <b>ARTERIOSCLEROTIC HEART DISEASE</b> DUE TO (c) <b>UNKNOWN</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH <b>RECENT</b>
PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>PULMONARY EMPHYSEMA MARKED</b>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (this hospital) attended the deceased from <b>10/11/67</b> , 19____, to <b>11/28/67</b> , 19____, that (we) last saw the deceased alive on <b>11/28/67</b> , 19____, and that death occurred at <b>1:30 A.</b> from causes and on the date stated above.							
22a. SIGNATURE <i>Peter V. Juvan</i>				MD ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22b. DATES SIGNED <b>11/28/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>PETER V. JUVAN, M. D.</b>				22d. ADDRESS <b>VAH FORT HOWARD, MARYLAND</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>12-1-67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>BALTIMORE NATIONAL</b>		23d. LOCATION (City or Town) (County) (State) <b>BALTIMORE, MARYLAND</b>	
24. FUNERAL DIRECTOR				25a. REC'D BY REGISTRAR <b>1967</b>		25b. REGISTRAR'S SIGNATURE <i>John S. Juvan</i>	

VR 111  
25M 1/67

PHILLIPS FUNERAL HOME  
1749 N. Monroe St. Baltimore, Md.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

14982		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		14987	
CERTIFICATE OF DEATH					
1 PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND			2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>✓</b>		
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>		c LENGTH OF STAY IN 1b <b>28 DAYS</b>		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>VETERANS ADMINISTRATION HOSPITAL</b>			d STREET ADDRESS <b>928 WICKLOW STREET</b>		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3 NAME OF DECEASED (Type or print) First: <b>KENNY</b> Middle: <b>-</b> Last: <b>HOOPER</b>			4. DATE OF DEATH Month: <b>NOVEMBER</b> Day: <b>7</b> Year: <b>1967</b>		
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>NEGRO</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>10/9/08</b>	9 AGE (n years last birthday) <b>59</b> yrs	IF UNDER 1 YEAR Months: Days: Hours: Min:
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LABORER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>REFINING COMPANY</b>		11. BIRTHPLACE (County & State, or foreign country) <b>LOTTSBURG, VIRGINIA</b>	
13 FATHER'S NAME <b>JOSHUA HOOPER</b>			12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>YES WW II</b>			16. SOCIAL SECURITY NO. <b>218 07 69 71</b>		
17 INFORMANT <b>CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.</b>			14. MOTHER'S MAIDEN NAME <b>HARRIET MN: UNKNOWN</b>		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>1810 CARCINOMA OF BLADDER WITH METASTASES</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <b>EMPHYSEMA OF BLADDER SEC. TO #1</b> (c) <b>ANEMIA AND CACHEXIA SEC. TO #1</b>					INTERVAL BETWEEN ONSET AND DEATH <b>7 YEARS</b>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour: <b>19</b> m. p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that <b>1</b> (this hospital) attended the deceased from <b>10/10/67</b> , 19 to <b>11/7/67</b> , 19, that <b>1</b> (we) last saw the deceased alive on <b>11/7/67</b> , 19, and that death occurred at <b>9:07 PM</b> , from causes and on the date stated above					
22a. SIGNATURE <i>Joseph J. Mowad</i> M.D.			22b. DATE SIGNED <b>11/8/67</b>		22c. PHYSICIAN'S NAME (Type) <b>JOSEPH J. MOWAD, M. D.</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>			23b. DATE THEREOF <b>11-13-67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>BALTIMORE NATIONAL</b>
24. FUNERAL DIRECTOR <b>ARLINGTON PHILLIPS</b>			23d. LOCATED ON (City or Town) <b>BALTIMORE, MARYLAND</b>		25a. REC'D BY REG. STRAR <b>NOV 10 1967</b>
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			25c. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		

1808 N. Monroe St. Baltimore, Md.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 11 and 12, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

14083

14088

1 PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>✓</b>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c LENGTH OF STAY IN TB	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Ridgeway Manor</b>		e STREET ADDRESS <b>Cathedral St.</b>	
3. NAME OF DECEASED (Type or print) <b>May Horner</b>		4. DATE OF DEATH Month <b>November</b> Day <b>11</b> Year <b>1967</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>9-7-1890</b>
9. AGE (In years last birthday) yrs <b>77</b>		10. F UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (County & State or foreign country) <b>Maryland</b>		12 CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>UNKNOWN Charles Martin</b>		14. MOTHER'S MAIDEN NAME <b>Catherine Gittinger</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16 SOCIAL SECURITY NO. <b>214-03-6074</b>	
17 INFORMANT <b>Mr. Dick Love, Baltimore, Md.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>3.31X cerebro-vascular acc</b> DUE TO (b) <b>hypertension</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>Jan 1966</b> to <b>11 Nov 1967</b> that (I) (we) last saw the deceased alive on <b>11 Nov 1967</b> , and that death occurred at <b>224A</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>William Goodman, M.D.</b>		22b. DATE SIGNED <b>11 Nov 67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. William Goodman</b>		22d. ADDRESS <b>1334 Sulphur Spring Road</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>11-14-67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Green Mount</b>	23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Maryland</b>
24 FUNERAL DIRECTOR <b>Mitchell-Wiedefeld Home 6500 York Rd.</b>		25a. REC'D BY REGISTRAR DATE <b>NOV 15 1967</b>	
		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
14084 CERTIFICATE OF DEATH										
1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson				c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Greater Baltimore Medical Center					d. STREET ADDRESS 917 Southerly Road			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First MIDDLE Last HARRY GILMORE HUFF			4. DATE OF DEATH Month Day Year November 6, 1967							
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 3, 1903		9. AGE (In years last birthday) 63 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Horse Trainer		10b. KIND OF BUSINESS OR INDUSTRY Horse Training		11. BIRTHPLACE (County & State, or foreign country) Pennsylvania			12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Harry G. Huff					14. MOTHER'S MAIDEN NAME Yancy (Maiden name not Known)					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes give war or dates of service) 213-20-9030		17. INFORMANT Mrs. Ruth Huff			Address Same as #2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ruptured Aortic Aneurysm DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) Arteriosclerotic Cardiovascular Disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hydronephrosis									INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 4:30 PM 11/6, 1967, to 7:50 PM 11/6, 1967, that (I) (we) last saw the deceased alive on November 6, 1967, and that death occurred at 7:50 PM, from the causes and on the date stated above.										
22a. SIGNATURE <i>Rudiger Breitenecker</i>					22b. DATE SIGNED 11/7/67					
22c. PHYSICIAN'S NAME (Type) Rudiger Breitenecker, M.D.					22d. ADDRESS Greater Baltimore Medical Center					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Nov. 9, 1967		23c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery		23d. LOCATION (City, town or county) (State) Woodlawn, Balt. Md.				
24. FUNERAL DIRECTOR Wm. Cook-Brooks Towson					25a. REC'D BY REGISTRAR NOV 8 1967		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			





FOR STATE  
HEALTH DEPT.

14985

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
c. LENGTH OF STAY IN 1b <b>Baltimore</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>7203 York Drive</b>		d. STREET ADDRESS <b>7203 York Drive</b>	
3 NAME OF DECEASED (Type or print) <b>SARA ELIZABETH HUTCHINSON</b>		4 DATE OF DEATH Month <b>November</b> Day <b>14</b> Year <b>1967</b>	
5 SEX <b>Female</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>10-24-1919</b>
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>WAITRESS</b>		10b KIND OF BUSINESS OR INDUSTRY <b>RESTAURANT</b>	9 AGE (In years last birthday) <b>48</b>
11 BIRTHPLACE (State or foreign country) <b>DELAWARE</b>		12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13 FATHER'S NAME <b>GEORGE T. HUTCHISON</b>		14 MOTHER'S M maiden NAME <b>NELLIE BEDWELL</b>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16 SOCIAL SECURITY NO <b>219-10-7121</b>	
17 INFORMANT <b>Mr. Robert Hutchison - 41 Paul Rd. New Castle Delaware</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> <b>491x</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <b>Metastatic Carcinoma</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspect an <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Edward F. Wilson</b> EXAMINER'S NAME (Type) <b>Edward F. Wilson, M.D.</b>		22. DATE SIGNED <b>November 15, 1967</b>	
23a BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b DATE THEREOF <b>11-17-67</b>	23c NAME OF CEMETERY OR CREMATORY <b>St. George's Cem.</b>	23d LOCATION (City or Town) (County) (State) <b>St. George's Delaware</b>
24 FUNERAL DIRECTOR <b>Funeral Home - 2334 Jefferson St.</b>		25a REC'D BY REGISTRAR <b>NOV 15 1967</b>	25b REGISTRAR'S SIGNATURE <b>Charles Judge</b>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



**HOSPITAL OF ATTENDING PHYSICIAN:** The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14986

CERTIFICATE OF DEATH

14991

1 PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. LENGTH OF STAY IN 1b <u>Baltimore</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Spring Grove State Hospital</u>		d. STREET ADDRESS <u>608 Kenox Street</u>	
3 NAME OF DECEASED (Type or print) <u>Wallace</u> First <u>Jaco</u> Middle Last		4 DATE OF DEATH Month <u>11</u> Day <u>23</u> Year <u>1967</u>	
5 SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>2/28/09</u>
9. AGE (In years last birthday) yrs <u>58</u>		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>Embalmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>West Virginia</u>	
11 BIRTHPLACE (County & State, or foreign country) <u>West Virginia</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>James Jaco.</u>		14. MOTHER'S MAIDEN NAME <u>  </u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16 SOCIAL SECURITY NO <u>235-18-1662</u>	
17 INFORMANT <u>Records: Spring Grove State Hospital</u>		Address <u>  </u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>liver insufficiency</u> DUE TO (b) <u>Obstructive jaundice</u> DUE TO (c) <u>Cholelithiasis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>  </u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>  </u>			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>  </u>	
20c TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>	20d INJURY OCCURRED While <input type="checkbox"/> Nat While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>	20f (City or town) (County) (State) <u>  </u>
21 I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>7-6-</u> , 19 <u>58</u> to <u>11-23-</u> , 19 <u>67</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>11-23-</u> , 19 <u>67</u> , and that death occurred at <u>12:15</u> M, from causes and on the date stated above			
22a. SIGNATURE <u>Ronald M. Smeets MD</u>		22b. DATE SIGNED <u>11-23-1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>RONALD M. SMEETS, MD</u>		22d. ADDRESS <u>Spring Grove State Hospital Baltimore, Maryland, 21208</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>  </u>	23b. DATE THEREOF <u>11/27/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>BLUEMONT CEM</u>	23d. LOCATION (City or Town) (County) (State) <u>GRAFTON W. VA.</u>
24. FUNERAL DIRECTOR <u>James M. Fields</u>		25a. REC'D BY REGISTRAR <u>4761 Bonnie Blvd</u>	
25b. REGISTRAR'S SIGNATURE <u>  </u>		DATE NOV 29 1967	



## CERTIFICATE OF DEATH

11987

14982

1 PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>North Carolina</b> b. COUNTY <b>Pasquotank</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>		c. LENGTH OF STAY IN 1b <b>3 Wks.</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Elizabeth City</b> <b>70</b>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>St. Joseph Hospital</b>		d. STREET ADDRESS <b>1606 Park View Drive</b>	
3 NAME OF DECEASED (Type or print) <b>ROBERT MORGAN JENNINGS</b>		4. DATE OF DEATH Month <b>November</b> Day <b>22</b> , Year <b>19 67</b>	
5 SEX <b>Male</b>	6 COLOR OR RACE <b>Cau.</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 17, 1898</b>
9. AGE (in years last birthday) <b>69 yrs.</b>		IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) <b>President &amp; Manager</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Industrial</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>North Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.A.</b>	
13. FATHER'S NAME <b>Miles Jennings</b>		14. MOTHER'S MAIDEN NAME <b>Edith Mann</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes W.W. One</b>		16. SOCIAL SECURITY NO. <b>237-03-0669A</b>	
17. INFORMANT <b>Mrs. Mildred Jennings, Same as # 2</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO <b>Coronary Occlusion</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Arteriosclerotic Cardiovascular Disease 3-4 y.</b> (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Carcinoma of the Oral Cavity</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Nov. 1, 1967</b> to <b>Nov 22, 1967</b> , that (I) (we) lost saw the deceased alive on <b>Nov 22, 1967</b> , and that death occurred at <b>9:40 A.M.</b> from causes and on the date stated above.			
22a. SIGNATURE <b>George F. Richards</b>		22b. DATE SIGNED <b>11/22/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>George F. Richards</b>		22d. ADDRESS <b>G. B. H. C. Towson, Md</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Nov. 25, 1967</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Old Hollywood Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Elizabeth City, N. C.</b>	
24. FUNERAL DIRECTOR <b>Wm. Cook-Brooks Towson, 1050 York Road Towson, Maryland 21204</b>		25a. REC'D BY REGISTRAR <b>NOV 27 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



14988

## CERTIFICATE OF DEATH

14983

1 PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u>		c. LENGTH OF STAY IN 1b <u>1 WK.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>2 SUNNY DALE WAY</u>		d. STREET ADDRESS <u>12 WILLOW AVENUE</u>	
3 NAME OF DECEASED (Type or print) First Middle Last <u>ALTHEA W. JOSE</u>		4. DATE OF DEATH Month Day Year <u>NOVEMBER 6 1967</u>	
5 SEX <u>FEMALE</u>	6 COLOR OR RACE <u>CAUCASIAN</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>AUGUST 8, 1903</u>
9 AGE (In years last birthday) <u>64 yrs</u>		10 IF UNDER 1 YEAR Months Days Hours Min <u>6 19 67</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE KEEPER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>SELF EMPLOYED</u>	
11 BIRTHPLACE (County & State or foreign country) <u>SALAMANCA GEORGIA</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>THADEUS WALKER</u>		14. MOTHER'S MAIDEN NAME <u>ANNIE FALGISH</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>N/C</u>		16. SOCIAL SECURITY NO <u>215-34-716A</u>	
17. INFORMANT <u>KATHLYN WELSH</u>		Address <u>WILLOW RD 21764</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) <u>ASCVD</u> (c) <u>10445</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 hr.</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that (1) (this hospital) attended the deceased from <u>NOV 6</u> , 19 <u>67</u> , to <u>NOV 6</u> , 19 <u>67</u> , that (1) (we) last saw the deceased alive on <u>SEP 30</u> , 19 <u>67</u> , and that death occurred at <u>7:15 AM</u> , from causes and on the date stated above			
22a SIGNATURE <u>Martin Feldman M.D.</u>		22b DATE SIGNED <u>11-6-67</u>	
22c PHYSICIAN'S NAME (Type) <u>MARTIN FELDMAN M.D.</u>		22d ADDRESS <u>1 CHERRY HILL RD REISTERTOWN MD</u>	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b DATE THEREOF <u>NOV 9, 1967</u>	
23c NAME OF CEMETERY OR CREMATORY <u>BALTL. NATIONAL CEM.</u>		23d LOCATION (City or Town) (County) (State) <u>BALTL. MD</u>	
24 FUNERAL DIRECTOR ADDRESS <u>DIFFEL BROS INC 7110 GLENN RD</u>		25a REC'D BY REGISTRAR <u>Charles Judge</u>	
25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>NOV 8 1967</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.





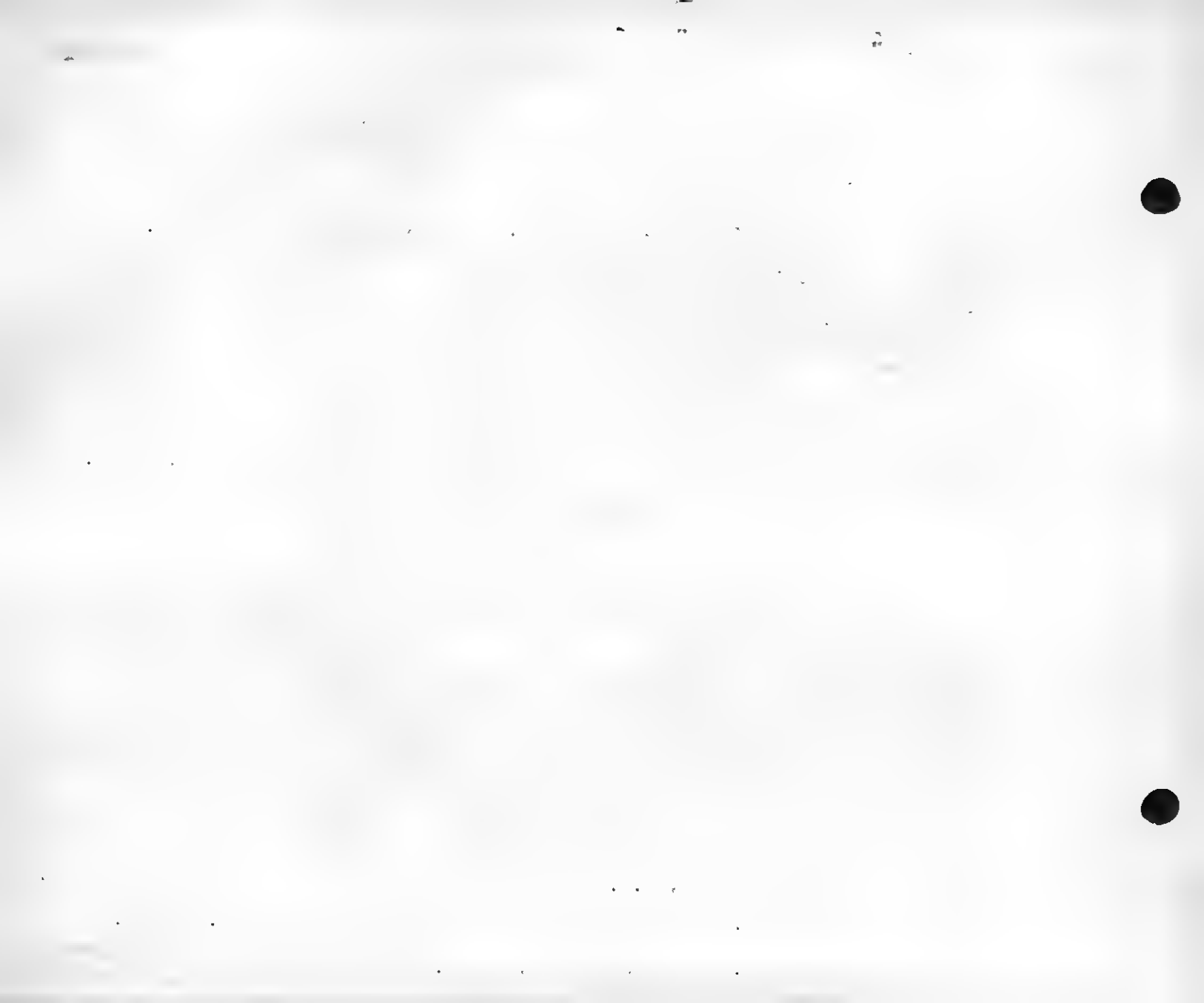
# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH			
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201			
MEDICAL EXAMINER'S CERTIFICATE OF DEATH			
1 PLACE OF DEATH a. COUNTY <b>Baltimore</b>		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <b>Unknown 21227</b>		c. LENGTH OF STAY IN 1b <b>20-4</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hosp. to give street address) <b>Field off 1500 block Sulphur Spring Rd.</b>		d. STREET ADDRESS <b>534 Random Rd.</b>	
3 NAME OF DECEASED (Type or print) First Middle Last <b>KATHERINE NANCY KANTROS</b>		4 DATE OF DEATH Month Day Year <b>November 28 19 67</b>	
5 SEX <b>Female</b>	6 COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>March 24, 1949</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Student</b>		10b. KIND OF BUSINESS OR INDUSTRY	9 AGE (in years lost birthday) <b>18-20 yrs</b>
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>		12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13 FATHER'S NAME <b>John Kantros</b>		14 MOTHER'S M A DEN NAME <b>Nancy Markli</b>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>?</b>	
17. INFORMANT <b>Mrs. Nancy Kane</b>		Address <b>534 Random Rd. Balto.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Multiple stab wounds of the back</b> <b>10 x 10</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) _____ (c) _____			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of Item 18) <b>Subject was stabbed and beaten</b>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>? p.m. ? 19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Unknown</b>	20f. (City or town) (County) (State) <b>Found at above location</b>
21 I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Edward F. Wilson</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Edward F. Wilson, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22. DATE SIGNED <b>November 30, 1967</b>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
Address (Street, city, town, or county) <b>Wm. Cook-Brooks, Inc. 1217 St. Paul St. Balto.</b>		23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	
23b. DATE THEREOF <b>Dec. 4, 1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Prospect Hill Cem</b>	
23d. LOCATION (City or town) (County) (State) <b>Towson, Md. Balto., Md.</b>		23e. REC'D BY REGISTRAR <b>DEC 4 1967</b>	
23f. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		23g. SIGNATURE OF REGISTRAR	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be retained by the hospital or attending physician.

VR A15 (4)  
15M 7/61

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed on pages 1 and 2, should be detached for use as the burial-transit permit. Then please remove carbon papers on pages 1 and 2, and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> c. LENGTH OF STAY IN 1b <u>10 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Baltimore County General Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>3401 GARRISON BLVD.</u> d. STREET ADDRESS <u>Baltimore Md. 21215</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>BESSIE M. Kaplan</u> 4. DATE OF DEATH <u>11-8-1967</u>		5. SEX <u>FEMALE</u> 6. COLOR OR RACE <u>WHITE</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>2-16-97</u> 9. AGE (In years last birthday) <u>70</u> yrs. 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u> 11. BIRTHPLACE (County & State, or foreign country) <u>MANCHESTER, N. H.</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Philip Magnus</u> 14. MOTHER'S MAIDEN NAME <u>JULIA GOLDSMITH</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>NO</u> 16. SOCIAL SECURITY NO. <u>025-12-3439</u> 17. INFORMANT <u>Robert</u> Address _____	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pericardial Fibrillation</u> DUE TO (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		INTERVAL BETWEEN ONSET AND DEATH <u>few minutes</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER.) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____		20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a.m. _____ p.m. _____ 20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	
20f. CITY or town _____ (County) _____ (State) _____		21. I certify that (I) (this hospital) attended the deceased from... <u>Oct. 30</u> ....., 19 <u>67</u> , to... <u>11-8</u> ....., 19 <u>67</u> , that (I) (we) last saw the deceased alive on... <u>11-8</u> ....., 19 <u>67</u> , and that death occurred at <u>11:50</u> AM, from the causes and on the date stated above.	
22a. SIGNATURE <u>Robert Y. Condon</u> 22c. PHYSICIAN'S NAME (Type) <u>Robert Y. Condon</u>		22b. DATE SIGNED _____ ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS _____	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u> 23b. DATE THEREOF <u>11-9-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>SHARON MEMORIAL PARK</u> 23d. LOCATION (City, town or county) <u>SHARON, MASSACHUSETTS</u> (State) _____	
24. FUNERAL DIRECTOR'S SIGNATURE <u>SOLLEVINSON &amp; BROS. INC.</u> ADDRESS <u>6010 REISTERSTOWN ROAD</u>		25a. REC'D BY REGISTRAR <u>NOV 13 1967</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



## CERTIFICATE OF DEATH

14996

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>Maryland</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURA, and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN lb <b>27 years</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>SPRING GROVE STATE HOSPITAL</b>		d. STREET ADDRESS <b>1632 North Montford Avenue</b>	
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>Henry</b> Last <b>Karl</b>		4. DATE OF DEATH Month <b>November</b> Day <b>6</b> Year <b>19 67</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1899</b>
9. AGE (In years last birthday) <b>68</b> yrs		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>printer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b>	
11. FATHER'S NAME <b>John Karl</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
13. MOTHER'S MAIDEN NAME <b>Barbara Schwartzman</b>		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>215-12-4641</b>	
17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Polyarteritis Nodosa, subacute, pre-symptomatic</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>2 mons.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Mitral Stenosis; ASCHD with hypertension secondary to prob- asle chronic glomerulonephritis</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <del>(this hospital)</del> attended the deceased from <b>Nov. 6</b> , 19 <b>67</b> to <b>Nov. 6</b> , 19 <b>67</b> , that <del>(we)</del> (we) last saw the deceased alive on <b>Nov. 6 1967</b> , and that death occurred at <b>9:00</b> M, from causes and on the date stated above			
22a. SIGNATURE <i>Anthony J. Young</i>		22b. DATE SIGNED <b>11-6-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Anthony J. Young, M.D.</b>		22d. ADDRESS <b>SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11/8/67.</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Md.</b>	
24. FUNERAL DIRECTOR <b>Leonard J. Ruck, Inc. Balto. Md. 21214</b>		25a. REC'D BY REGISTRAR <b>NOV 7 1967</b>	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

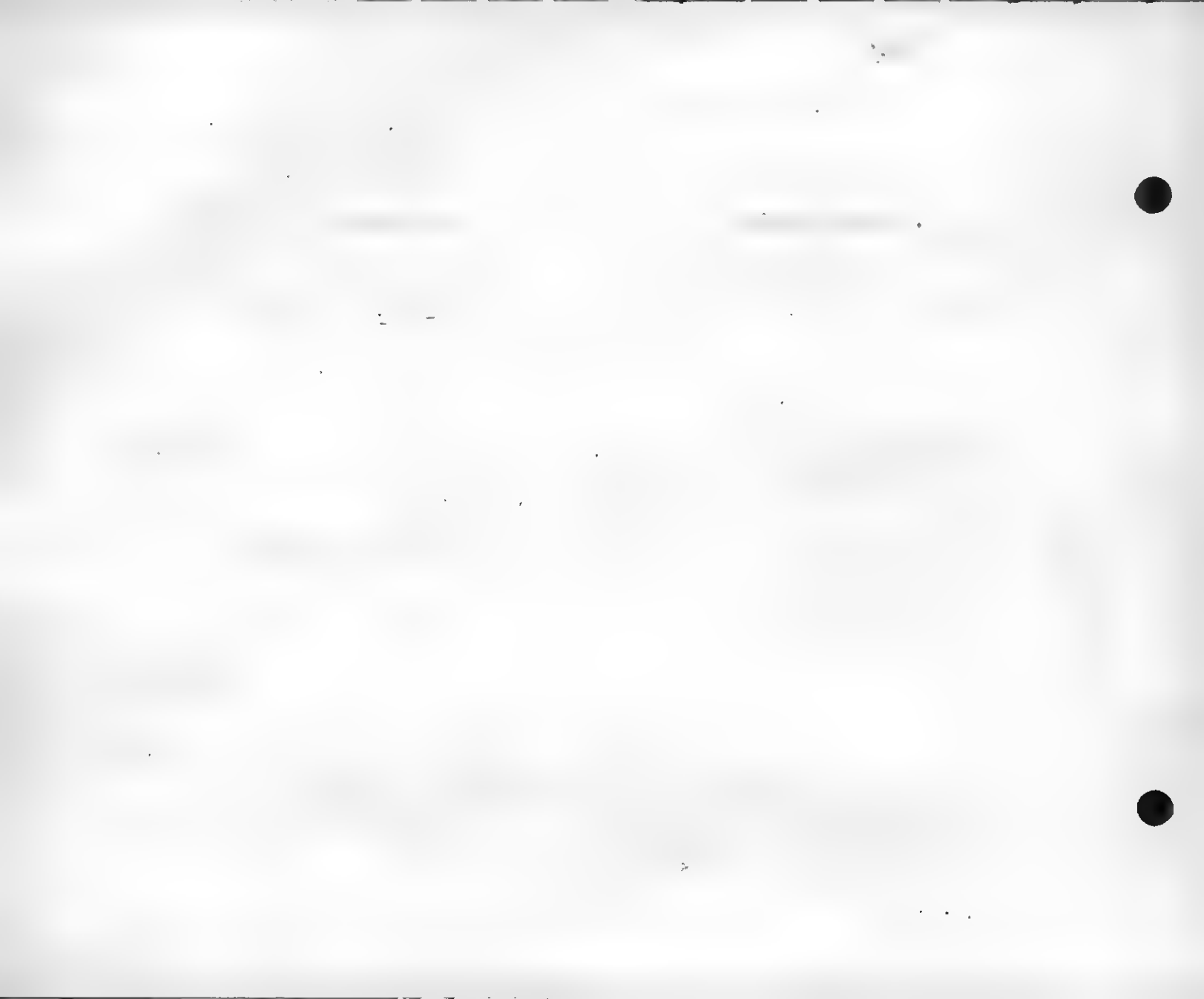
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div style="text-align: center;"> <b>MARYLAND STATE DEPARTMENT OF HEALTH</b>  <b>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</b>  <b>CERTIFICATE OF DEATH</b> </div> <div style="text-align: right;">14087</div>									
1. PLACE OF DEATH a. COUNTY <b>Baltimore County</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Towson</b>				c. LENGTH OF STAY IN 1b <b>2 Hours</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Perry Hall, Md.</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>St. Joseph Hospital</b>				d. STREET ADDRESS <b>9807 Gunforge Rd. 21236</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Sarah</b> Middle <b>Keen</b> Last <b>Keen</b>				4. DATE OF DEATH Month <b>11</b> Day <b>20</b> Year <b>1967</b>					
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1-5-1873</b>		9. AGE (In years last birthday) <b>94</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Housewife</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore City Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Rose</b>				14. MOTHER'S MAIDEN NAME <b>Elva Stockman</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>212-50-6500</b>		17. INFORMANT Address <b>Mrs Helen C. Friesner 9807 Gunforge Road</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Circulatory collapse</b> DUE TO (b) <b>Arteriosclerotic Cardiovascular disease</b> DUE TO (c) <b>Cardiac Arrest</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								INTERVAL BETWEEN ONSET AND DEATH <b>4 hours</b> <b>20 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Aug 10, 1965</b> to <b>Apr 11, 1967</b> , that (I) (we) last saw the deceased alive on <b>Apr 11, 1967</b> , and that death occurred at <b>9:20 AM</b> , from the causes and on the date stated above.									
22a. SIGNATURE <b>Samuel J. O'Malley</b>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>in 2067</b>			
22c. PHYSICIAN'S NAME (Type) <b>Samuel J. O'Malley</b>				22d. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>11-22-67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>BALTIMORE CEM.</b>		23d. LOCATION (City, town or county) (State) <b>BALTO, MD</b>			
24. FUNERAL DIRECTOR <b>Joseph Funeral Home 7401 Belair Road</b>				ADDRESS <b>36</b>		25a. REC'D BY REGISTRAR <b>NOV 27 1967</b>		25b. REGISTRAR'S SIGNATURE <b>William A. Jones</b>	





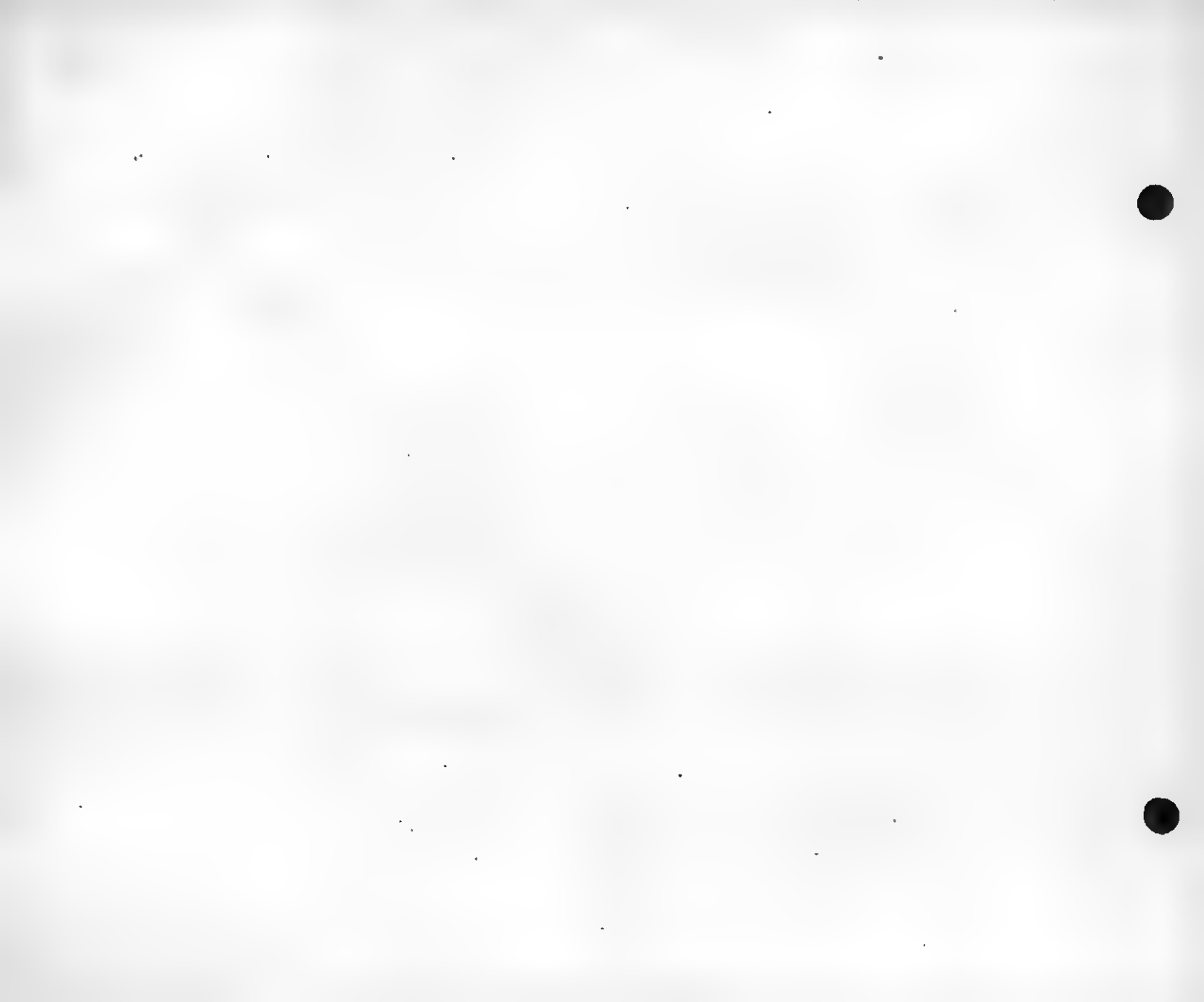
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH ■ COUNTY <b>BALTIMORE</b> ■ CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MD</b> b. COUNTY <b>HOWARD</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RT #1 Box 218 LAURELIND</b>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>GREATER BALTO. MEDICAL CENTER</b>						d. STREET ADDRESS <b>1311 1/2 W. 1st St. Baltimore 1, Md.</b>					
3. NAME OF DECEASED (Type or print) First <b>MAUDE</b> Middle <b>KEIRSEY</b> Last <b>KEIRSEY</b>						4. DATE OF DEATH Month <b>11</b> Day <b>10</b> Year <b>1967</b>					
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>CAU</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>9-12-18</b>		9. AGE (In years last birthday) <b>49</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				11b. KIND OF BUSINESS OR INDUSTRY <b>None</b>				11. BIRTHPLACE (County & State, or foreign country) <b>Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>JASPER Collier</b>						14. MOTHER'S MAIDEN NAME <b>Mally WALDON</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>						16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>James Keirsey, Laurel Md</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>1210 Uremia</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>Carcinoma of the Bladder.</b> DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										INTERVAL BETWEEN ONSET AND DEATH <b>4 w 6 mo.</b>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>Aug. 1967</b> to <b>10 Nov 1967</b> , that (I) (we) last saw the deceased alive on <b>10 Nov 1967</b> and that death occurred at <b>11 PM</b> , from the causes and on the date stated above.											
22a. SIGNATURE <b>George J. Richards Jr.</b>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>11/10/67</b>			
22c. PHYSICIAN'S NAME (Type) <b>George J. Richards Jr.</b>						22d. ADDRESS <b>G.B.H.C. Balt 21207</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <b>11-14-67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Highland Cemetery</b>				23d. LOCATION (City, town or county) (State) <b>Rogersville Tenn.</b>			
24. FUNERAL DIRECTOR <b>W. W. Darnedean</b>				ADDRESS <b>Laurel Md</b>		25a. REC'D BY REGISTRAR <b>NOV 16 1967</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>			

MEDICAL CERTIFICATION







TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it must be completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
15090											
1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>TOWSON</b>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Rogers Forge</b>					
c. LENGTH OF STAY IN 1b <b>3 DAY</b>						d. STREET ADDRESS <b>201 MURDOCK ROAD</b>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>GREATER BALTIMORE MEDICAL CENTRE</b>											
3. NAME OF DECEASED (Type or print) First <b>ELVIE</b> Middle <b>L.</b> Last <b>KEMPTON</b>						4. DATE OF DEATH Month <b>NOVEMBER</b> Day <b>5</b> Year <b>1967</b>					
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>CAU</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>2-21-71</b>		9. AGE (in years last birthday) <b>96</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>New Hampshire</b>			12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME <b>Hiram Kempton</b>						14. MOTHER'S MAIDEN NAME <b>Marg E. Webster</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b>				16. SOCIAL SECURITY NO. <b>W.W.I</b>		17. INFORMANT Address <b>Mrs. Palmer H. Hobday 201 Murdock Rd.</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardio-Respiratory failure</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <b>ca of Prostate</b> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>											
MEDICAL CERTIFICATION											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>11.2</b> , 19 <b>62</b> , to <b>11.5</b> , 19 <b>62</b> , that (I) (we) last saw the deceased alive on <b>11.5</b> , 19 <b>67</b> , and that death occurred at <b>1:55</b> M, from the causes and on the date stated above.											
22a. SIGNATURE <b>Ruth M. Bann</b>										22b. DATE SIGNED <b>11-5-67</b>	
22c. PHYSICIAN'S NAME (Type)						22d. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (State type) <b>Cremation</b>				23b. DATE THEREOF <b>11/8/1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Greenmount</b>			23d. LOCATION (City, town or county) (State) <b>Balto. Md.</b>		
24. FUNERAL DIRECTOR ADDRESS <b>Mitchell-Wiedefeld Home 6500 York Rd.</b>						25a. REC'D BY REGISTRAR <b>NOV 9 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



VR A15 (4)  
15M 4-64

(4)

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>9506 Powderhorn Lane</b>		d. STREET ADDRESS <b>309 E. 25th St.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>MARY M. KINSELLA</b>		4. DATE OF DEATH Month <b>November</b> Day <b>24</b> Year <b>1967</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 18, 1897</b>
9. AGE (In years last birthday) <b>70</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>Galway Ireland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>James Moran</b>		14. MOTHER'S MAIDEN NAME <b>Catherine ?</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>215-07-9131</b>	
17. INFORMANT <b>Mrs. Catherine White: 9506 Powderhorn Lane-14</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Vascular Accident</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <b>Arteriosclerotic Comp. Vascular Min</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes Mellitus</b>		INTERVAL BETWEEN ONSET AND DEATH <b>5 yrs.</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Aug. 1960</b> to <b>Nov. 24, 1967</b> , that (I) (we) last saw the deceased alive on <b>Nov. 24, 1960</b> , and that death occurred at <b>10:45 AM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>A. A. SILVER</b>		22b. DATE SIGNED <b>Nov. 24, 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>A. A. SILVER</b>		22d. ADDRESS <b>6210 PARK HEIGHT AVE</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		23b. DATE THEREOF <b>11/28/67.</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Baltimore, Md.</b>	
24. FUNERAL DIRECTOR <b>Leonard J. Ruck, Inc: Baltimore, Md....14</b>		25a. REC'D BY REGISTRAR DATE <b>NOV 27 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			





DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

Item #8 c11478175 11/21/2000

5202

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b>		c. LENGTH OF STAY IN 1b <b>BALTIMORE</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>MILFORD MANOR NURSING HOME</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before adm'ssion) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b>	
3. NAME OF DECEASED (Type or print) <b>REBECCA</b>		4. DATE OF DEATH <b>Nov 9 1967</b>		5. AGE (In years) <b>61 yrs.</b>	
6. COLOR OR RACE <b>W</b>		7. MARIED <input type="checkbox"/> NEVER MARIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Dec 18, 1906</b>	
9. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>USA</b>	
12. FATHER'S NAME		13. MOTHER'S MAIDEN NAME		14. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>	
15. SOCIAL SECURITY NO. <b>212-52-2490</b>		16. INFORMANT <b>DR BRUCE HORNSTEIN</b>		17. ADDRESS <b>7002 AIDEN RD</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia (terminal)</b> <b>443X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>H A J H D</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> <b>77 years</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>3/15</b> 1964 to <b>11/9</b> 1967, that (I) (we) last saw the deceased alive on <b>11/5</b> 1967, and that death occurred at <b>BRAM</b> , from the causes and on the date stated above.					
22a. SIGNATURE <b>[Signature]</b>		22b. DATE SIGNED <b>11/9/67</b>		22c. PHYSICIAN'S NAME (Type) <b>[Signature]</b>	
22d. ADDRESS		22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22f. ADDRESS	
23a. BURIAL, CREMATION, 23b. DATE THEREOF REMOVAL (Specify) <b>Burial 11/9/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>W. T. Carmichael</b>		23d. LOCATION (City, town or county) (State) <b>Baltimore Md</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Sylvan S. Lewis &amp; Son, INC</b>		24a. ADDRESS <b>Gaithersburg, Md</b>		24b. REC'D BY REGISTRAR <b>NOV 13 1967</b>	
24c. REGISTRAR'S SIGNATURE <b>[Signature]</b>		24d. REGISTRAR'S SIGNATURE <b>[Signature]</b>		24e. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (1-75)  
25M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14993

15003

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. LENGTH OF STAY IN 1b <u>Baltimore</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Spring Grove State Hospital</u>		d. STREET ADDRESS <u>4012 Maine Avenue</u>	
3. NAME OF DECEASED (Type or print) First <u>Grace</u> Middle <u>Ann</u> Last <u>Kirby</u>		4. DATE OF DEATH Month <u>11</u> Day <u>23</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-21-75</u>
9. AGE (in years last birthday) <u>92 yrs</u>		10. IF UNDER 1 YEAR Months <u>2</u> Days <u>1</u> Hours <u>2</u> Min <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Joseph Winbel</u>		14. MOTHER'S MAIDEN NAME <u>Mary Anne E. Walz</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>218-50-7382</u>	
17. INFORMANT <u>Records: Spring Grove State Hospital</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart Failure</u> DUE TO (b) <u>Arteriosclerotic cardiovascular disease</u> DUE TO (c) <u>Anteroselective cardiovascular disease</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>paralytic ileus</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>a.m.</u> <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>12-29-1966</u> to <u>11-23-1967</u> , that (i) (we) last saw the deceased alive on <u>11-23-1967</u> , and that death occurred at <u>2:10 P.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Ronald M. Smeets MD</u>		22b. DATE SIGNED <u>11-23-1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>RONALD M. SMEETS, MD</u>		22d. ADDRESS <u>Spring Grove State Hospital Baltimore, Maryland 21220</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>11/27/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Holy Cross</u>	23d. LOCATION (City or Town) (County) (State) <u>Baltimore Maryland</u>
24. FUNERAL DIRECTOR <u>Leonard J Ruck Inc 5305 Harford Rd</u>		25a. REC'D BY REGISTRAR <u>NOV 24 1967</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>



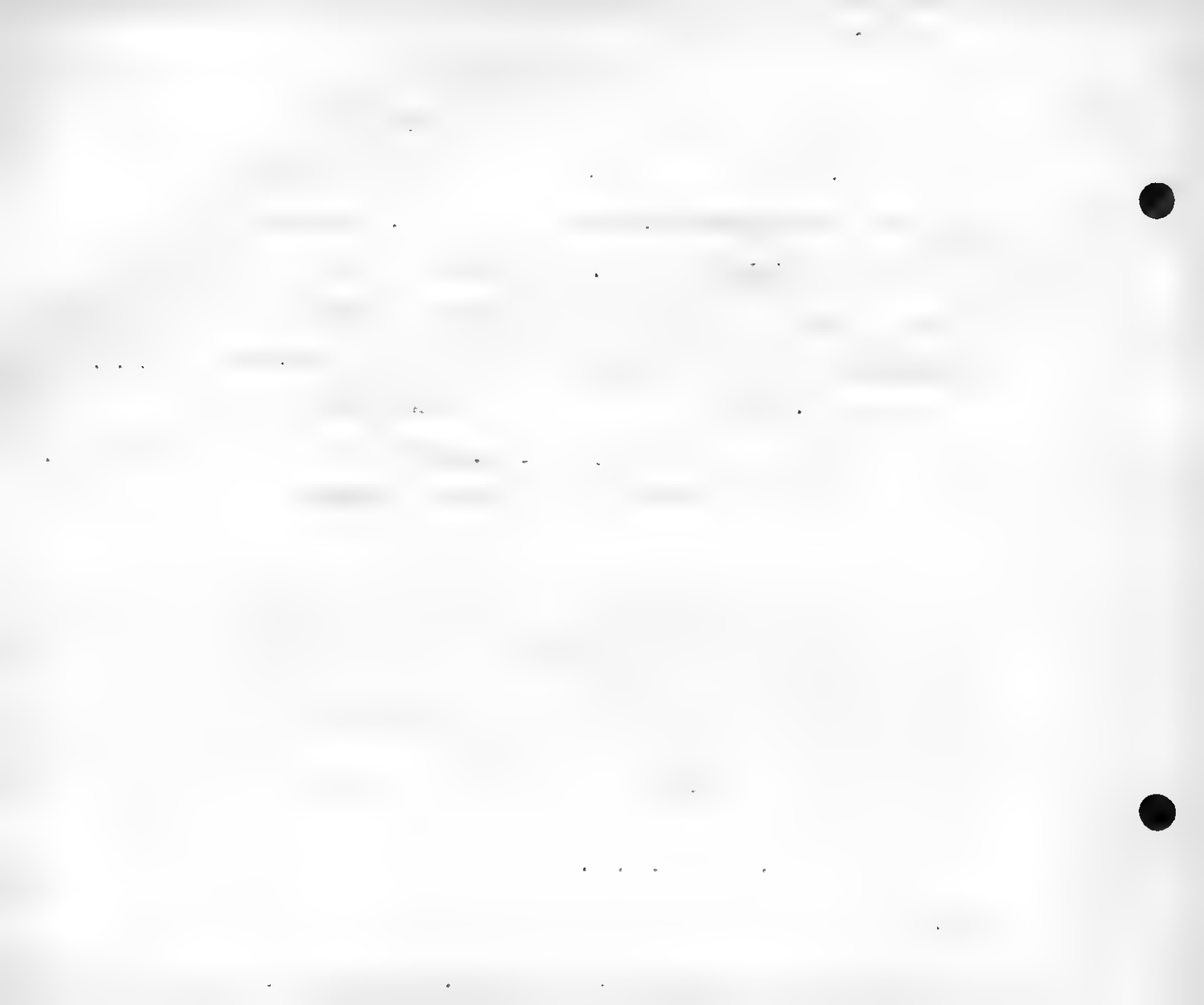
## CERTIFICATE OF DEATH

15576

1 PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD, MARYLAND</b>		c. LENGTH OF STAY IN lb <b>25 DAYS</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>VETERANS ADMINISTRATION HOSPITAL</b>		d. STREET ADDRESS <b>3246 E. BALTIMORE STREET</b>	
3 NAME OF DECEASED (Type or print) First <b>WALTER</b> Middle <b>W.</b> Last <b>KOHLER</b>		4 DATE OF DEATH Month <b>NOVEMBER</b> Day <b>30</b> Year <b>19 67</b>	
5 SEX <b>MALE</b>	6 COLOR OR RACE <b>WHITE</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> <b>Divorced</b> <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>JANUARY 12, 1916</b>
9. AGE (In years lost birthday) <b>51 yrs</b>		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>WAREHOUSEMAN</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>WAREHOUSE</b>	
11 BIRTHPLACE (Country & State, or foreign country) <b>HARRISBURG, PENNSYLVANIA</b>		12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>CHARLES E. KOHLER</b>		14. MOTHER'S MAIDEN NAME <b>ANNA HUGHES</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>YES WW II</b>		16. SOCIAL SECURITY NO <b>172 01 55 39</b>	
17 INFORMANT <b>CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.</b>		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>CARCINOMA OF LUNG WITH METASTASES</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			INTERVAL BETWEEN ONSET AND DEATH <b>MONTHS</b>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>11/5/67</b> , 19 to <b>11/30/67</b> , 19, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>11/30/67</b> , 19, and that death occurred at <b>10:40 AM</b> from causes and on the date stated above.			
22a SIGNATURE <i>John D. Talbert</i>		22b DATE SIGNED <b>11/30/67</b>	
22c PHYSICIAN'S NAME (Type) <b>JOHN D. TALBERT, M. D.</b>		22d ADDRESS <b>VAH FORT HOWARD, MARYLAND</b>	
23a BURIAL, CREMATON, REMOVAL (Specify) <b>BURIAL</b>	23b DATE THEREOF <b>12/5/67</b>	23c NAME OF CEMETERY OR CREMATORY <b>BALTIMORE NATIONAL</b>	23d LOCATION (City or Town) (County) (State) <b>BALTIMORE, MARYLAND</b>
24 FUNERAL DIRECTOR <i>Joseph N. Zannino</i>		25a RECEIVED BY REGISTRAR <b>DEC 7 1967</b>	
25b REGISTRAR'S SIGNATURE <i>James J. Jones</i>		25c ADDRESS <b>ZANNINO FUNERAL HOME</b> <b>257 S. CONKLING ST. BALTIMORE, MD.</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 or 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, or in any event, within 72 hours after death.



CERTIFICATE OF DEATH

15000

15004

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-papers. Pages 4 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>		c. LENGTH OF STAY IN IB	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>341 Whitfield Rd.</b>		d. STREET ADDRESS <b>341 Whitfield Rd.</b>	
3 NAME OF DECEASED (Type or print) <b>John Charles Korter</b>		4 DATE OF DEATH Month <b>November</b> Day <b>4</b> Year <b>1967</b>	
5 SEX <b>Male</b>	6 COLOR OR RACE <b>Cauc.</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8/19/99</b>
9. AGE (In years last birthday) yrs <b>68</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Penn. RR</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Charles Korter</b>		14. MOTHER'S MAIDEN NAME <b>Veronica Bauer</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>yes</b>		16. SOCIAL SECURITY NO. <b>1-11-1</b>	
17. INFORMANT <b>Mrs. Charles Korter</b>		Address <b>341 Whitfield Rd.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>arteriosclerotic coronary artery disease</b> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs +</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (the hospital) attended the deceased from <b>1965</b> , 19____, to <b>Nov 4</b> , 19 <b>67</b> ; that (I) (we) last saw the deceased alive on <b>9-22-67</b> 19____, and that death occurred at <b>7:00 A.M.</b> , from causes on and on the date stated above			
22a. SIGNATURE <b>John A. Nesbitt Jr.</b>		22b. DATE SIGNED <b>11-4-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>John A. Nesbitt Jr.</b>		22d. ADDRESS <b>1009 Frederick Rd.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>11/7/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Druid Ridge Cem.</b>	23d. LOCATION (City or town) (County) (State) <b>Baltimore, Md.</b>
24. FUNERAL DIRECTOR <b>Witzke Funeral Dir. 4101 Edmondson Ave.</b>		25a. RECEIVED BY REGISTRAR DATE <b>NOV 6 1967</b>	
		25b. REGISTRAR'S SIGNATURE <b>John A. Nesbitt Jr.</b>	





# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 100-1. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15005

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>BALTO</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>BALTO</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ESSEX</b>		c. LENGTH OF STAY IN 1b <b>ESSEX</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>710 S. MARLYN</b>		d. STREET ADDRESS <b>710 S. MARLYN</b>	
3. NAME OF DECEASED (Type of print) First <b>MARY</b> Middle <b>KOS</b> Last <b>NOV.</b>		4. DATE OF DEATH Month <b>NOV.</b> Day <b>28</b> Year <b>1967</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>NOV. 8 1892</b>
9. AGE (in years last birthday) <b>75</b> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <b>10b. KIND OF BUSINESS OR INDUSTRY</b>	
11. BIRTHPLACE (State or foreign country) <b>POLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>STANLEY KOWALSKI</b>		14. MOTHER'S MAIDEN NAME <b>P</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO <b>—</b>	
17. INFORMANT <b>FRANK KOS</b>		Address <b>ABOVE</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>4201 Gentle Coronary Occlusion</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>ACVD</b> DUE TO (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office, etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Theo C Patterson</b> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>THEO C PATTERSON</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
		Address (Street, city, town, or county)	
23a. BURIAL (CREMATION, REMOVAL) (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>12/1/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>OAK LAWN CEM</b>	23d. LOCATION (City or Town) (County) (State) <b>BALTO. MD.</b>
24. FUNERAL DIRECTOR <b>J.B. CONNELLY SONS</b>		25a. REC'D BY REGISTRAR <b>DEC 1 1967</b>	
ADDRESS <b>300 MACE</b>		25b. REGISTRAR'S SIGNATURE <b>James Judge</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

158



Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17903

Item 23c 3-11 Telephone conversation with hospital

15002

## CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Towson</b> c. LENGTH OF STAY IN lb <b>15002</b>			2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore 21236</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore 21236</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>ST. JOSEPH HOSPITAL</b>			d. STREET ADDRESS <b>9104 Carlisle Ave.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <b>Ronald Kotowski</b> First Middle Last			4. DATE OF DEATH <b>November 30, 1967</b> Month Day Year		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>November 27, 1967</b>		9. AGE (In years last birthday) yrs <b>3</b> IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore, Maryland</b>	
13. FATHER'S NAME <b>Walter James Kotowski</b>			14. MOTHER'S MAIDEN NAME <b>Rita Marie Tyszkiewicz</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO		17. INFORMANT Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Multiple congenital anomalies.</b> <b>1273</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) _____ DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>11/27/</b> , 19 <b>67</b> , to <b>11/30/</b> , 1967, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>11/30/</b> , 19 <b>67</b> , and that death occurred at <b>3:20PM</b> , from causes and on the date stated above.					
22a. SIGNATURE  M.D.			ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>December 1, 1967</b>
22c. PHYSICIAN'S NAME (Type) <b>Lawrence F. Misanik, M.D.</b>			22d. ADDRESS <b>7620 York Rd., Towson, Md. 21204</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY <b>U. of M. Anatomy Board</b>	
23d. LOCATION (City or town) (County) (State)		23e. REC'D BY REGISTRAR DATE <b>DEC 13 1967</b>		23f. REGISTRAR'S SIGNATURE 	
24. FUNERAL DIRECTOR ADDRESS		24b. REGISTRAR'S SIGNATURE			



## CERTIFICATE OF DEATH

15003

15006

1. PLACE OF DEATH a. COUNTY <u>Baltimore, Maryland</u> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Chesapeake Manor, Baltimore</u>		d. STREET ADDRESS <u>1312 S. Charles St.</u>	
3. NAME OF DECEASED (Type or print) First <u>Ervin</u> Middle <u>L.</u> Last <u>Krall</u>		4. DATE OF DEATH Month <u>November</u> Day <u>1</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July</u> , <u>1936</u>
9. AGE (In years last birthday) <u>31</u> yrs.		10. IF UNDER 1 YEAR Months <u>1</u> Days <u>1</u> Hours <u>1</u> Min. <u>1</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Owner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Trucking</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Krall</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Krall</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>131-15-1067</u>	
17. INFORMANT <u>Mrs. Helen G. Krall</u>		Address <u>1312 S. Charles St.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PNEUMONIA, TERMINAL</u> DUE TO (b) <u>CACHEXIA - MULTIPLE DEGENERATION</u> DUE TO (c) <u>SEMI-ASCVD</u>		INTERVAL BETWEEN ONSET AND DEATH <u>DAYS</u> <u>MONTHS</u> <u>YEARS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Nov 1st 1967</u> to <u>Nov 1st 1967</u> that (I) (we) last saw the deceased alive on <u>Nov 1st 1967</u> , and that death occurred at <u>11:15</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>Ervin L. Krall</u> M.D.		22b. DATE SIGNED <u>Nov 2 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>Dr. Enrique Moszkowski</u>		22d. ADDRESS <u>1111 Park Ave.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		23b. DATE THEREOF <u>11 1 67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>London Park</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Charles Judge</u>		25a. REC'D BY REGISTRAR DATE <u>NOV 3 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers: Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4-75)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
15004											
15007											
CERTIFICATE OF DEATH											
1 PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND						2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>_____</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>				c. LENGTH OF STAY IN 1b <b>25 DAYS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>VETERANS ADMINISTRATION HOSPITAL</b>						d. STREET ADDRESS <b>1334 NORTH CHESTER STREET</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <b>NATHANIEL P LADSON</b>			First Middle Last			4 DATE OF DEATH Month Day Year <b>NOVEMBER 25 19 67</b>					
5 SEX <b>MALE</b>		6 COLOR OR RACE <b>NEGRO</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>MAY 5, 1919</b>		9. AGE (n years last birthday) <b>48 yrs</b>		f. UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>BRICKLAYER</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>CONSTRUCTION</b>		11 BIRTHPLACE (County & State, or foreign country) <b>SHULVILLE, S.C.</b>				12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Unknown</b>						14. MOTHER'S MAIDEN NAME <b>Mariah Ladson</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>YES WWII</b>				16. SOCIAL SECURITY NO <b>247 20 50 02</b>		17. INFORMANT <b>CLINICAL RECORDS VAH FORT HOWARD, MD</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))											
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>151x MALNUTRITION AND DEHYDRATION</b>										INTERVAL BETWEEN ONSET AND DEATH <b>MONTHS</b>	
DUPLICATE (b) <b>GENERALIZED METASTATIC DISEASE</b>										<b>3 YEARS</b>	
DUPLICATE (c) <b>CARCINOMA OF THE STOMACH</b>										<b>3 YEARS</b>	
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>10 31 67</b> , 19____, to <b>11 25 67</b> 19____, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>11 25 67</b> 19____, and that death occurred at <b>11:05 AM</b> , from causes and on the date stated above.											
22a. SIGNATURE <b>Richard R. Stephenson MD.</b>						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22b. DATE SIGNED <b>11 25 67</b>		
22c. PHYSICIAN'S NAME (Type) <b>RICHARD R. STEPHENSON</b>						22d. ADDRESS <b>VA HOSPITAL FORT HOWARD, MD</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>			23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY <b>NATIONAL CEMETERY</b>			23d. LOCATION (City or Town) (County) (State) <b>BALTIMORE, MARYLAND</b>			
24. FUNERAL DIRECTOR <b>COLLICK FUNERAL HOME</b>						25a. REC'D BY REGISTRAR <b>NOV 28 1967</b>		25b. REGISTRAR'S SIGNATURE <b>OLIVER ST. BALTIMORE, MARYLAND</b>			





# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

15005

15008

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers - Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>11</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RANDALLSTOWN</b>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RANDALLSTOWN</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>BALTIMORE COUNTY GENERAL HOSPITAL</b>				d. STREET ADDRESS <b>8410 ALLENSWOOD ROAD</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First <b>FLORINE</b> Middle <b>LAFFERMAN</b> Last				4 DATE OF DEATH <b>NOVEMBER 23, 19 67</b> Month Day Year			
5 SEX <b>FEMALE</b>	6 COLOR OR RACE <b>WHITE</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>7/27/31</b>	9. AGE (In years last birthday) <b>36</b> yrs	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CLERK</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U. S. GOVERNMENT</b>		11. BIRTHPLACE (County & State, or foreign country) <b>BALTIMORE, MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>LOUIS TAMRES</b>				14. MOTHER'S MAIDEN NAME <b>DORA KARSH</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>218-28-4248</b>		17. INFORMANT Address <b>MR. HERBERT LAFFERMAN, 8410 ALLENSWOOD ROAD</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1. DEATH WAS CAUSED BY 4711 IMMEDIATE CAUSE (a) <b>Severe diffuse pulmonary edema, + hemorrhage - Bilateral hemorrhage</b> DUE TO (b) <b>Broncho pneumonia</b> Condit ans, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)							INTERVAL BETWEEN ONSET AND DEATH <b>Hours</b>
PART 1. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) <b>Diabetes</b>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 1 of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour o m. p m <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>1963</b> to <b>11/23, 1967</b> , that (I) (we) lost the deceased alive on <b>8/29 19 67</b> , and that death occurred at <b>8:15 PM</b> , from causes and on the date stated above.							
22a. SIGNATURE <b>Dr. Morton J. Ellin</b>				M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED <b>11/25/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>DR. MORTON J. ELLIN</b>		22d. ADDRESS <b>8629 LIBERTY ROAD</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>11-26-67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ANSHE EMUNAH AITZ CHAIM</b>		23d. LOCATION (City or Town) (County) (State) <b>BALTIMORE, MARYLAND</b>	
24. FUNERAL DIRECTOR <b>SOL LEVINSON &amp; BROS. INC., 6010 REISTERSTOWN ROAD</b>				25a. REC'D BY REGISTRAR DATE <b>NOV 28 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

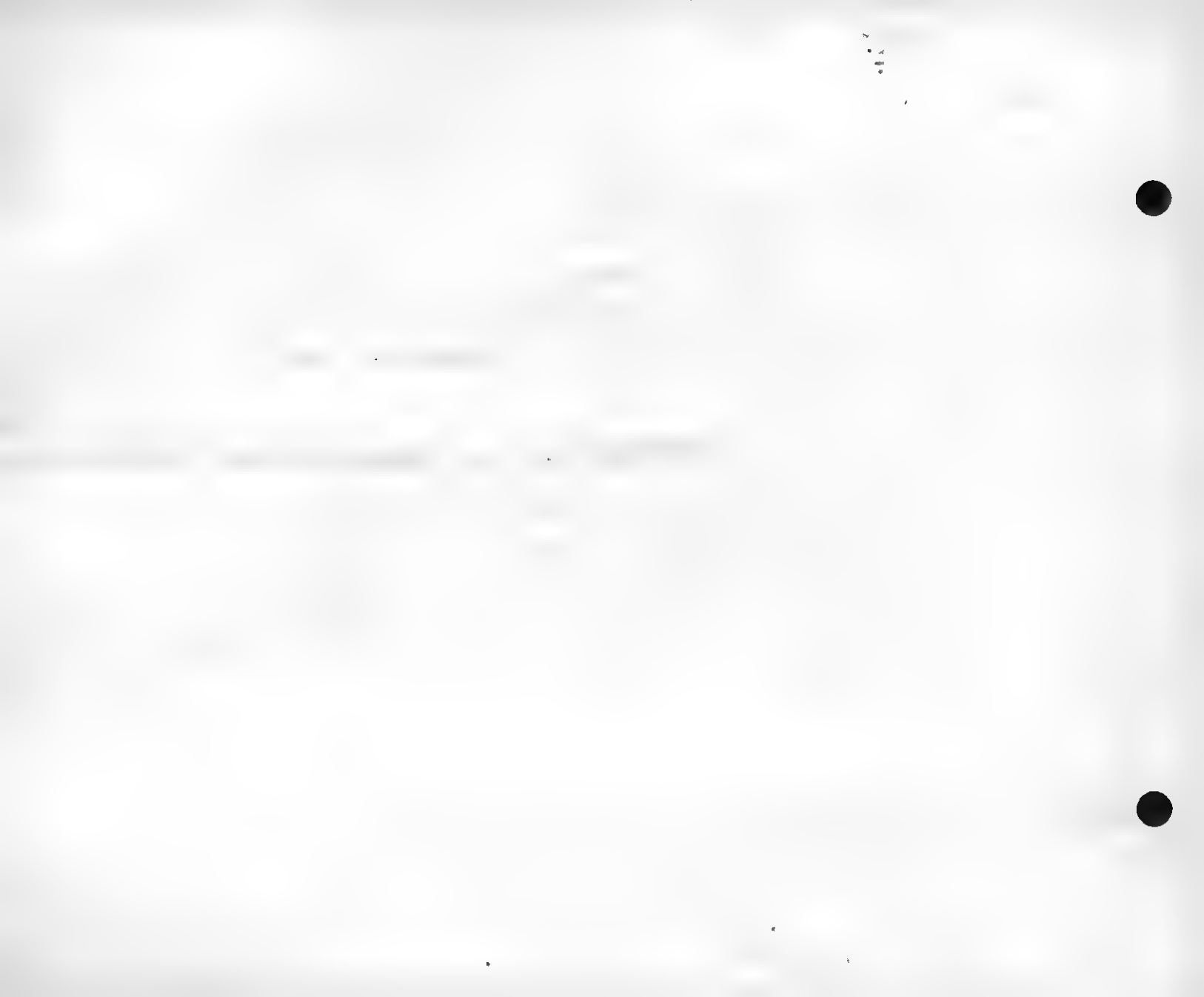


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Notonsville</u>				c. LENGTH OF STAY N 1b <u>21 19 '67</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Reisterstown, Md.</u>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Spring Grove State Hospital</u>						d. STREET ADDRESS <u>170 Westminster Rd.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Louise</u> Last <u>LeFevre</u>						4. DATE OF DEATH Month <u>11</u> Day <u>19</u> Year <u>1967</u>					
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9/18/03</u>		9. AGE (In years last birthday) <u>64</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>  </u>		11. BIRTHPLACE (County & State, or foreign country) <u>Carroll Co., Md.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles Theodore McKinney</u>						14. MOTHER'S MAIDEN NAME <u>Ada Coleman</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>				16. SOCIAL SECURITY NO. <u>212-26-6192</u>		17. INFORMANT <u>(chart) Edward LeFevre</u> Address <u>170 Westminster Rd. Reisterstown, Md.</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>prob. extension of myocardial infarction</u> DUE TO (b) <u>pulmonary edema - intermittent</u> DUE TO (c) <u>myocardial ischemia → infarction</u>										INTERVAL BETWEEN ONSET AND DEATH <u>1 hr.</u> <u>1 wk.</u> <u>2 wks.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>alcoholism; chronic brain syndrome</u>										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>NO</u>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part I of item 18) <u>  </u>							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>		20f. (City or town) (County) (State) <u>  </u>			
21. I certify that (I) (this hospital) attended the deceased from <u>  </u> , 19 <u>  </u> , to <u>  </u> , 19 <u>  </u> , that <u>(I)</u> (we) last saw the deceased alive on <u>11/19</u> 19 <u>67</u> , and that death occurred at <u>2:05</u> AM, from causes and on the date stated above.											
22a. SIGNATURE <u>Amelinda Silva</u>						M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>11/19/67</u>			
22c. PHYSICIAN'S NAME (Type) <u>  </u>						22d. ADDRESS <u>  </u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Nov. 22, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Evergreen Mem. Gardens Finksburg, Maryland</u>				23d. LOCATION (City or Town) (County) (State) <u>  </u>			
24. FUNERAL DIRECTOR <u>H. J. Edhardt</u>						ADDRESS <u>Owings Mills, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>NOV 21 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Pharis Judge</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

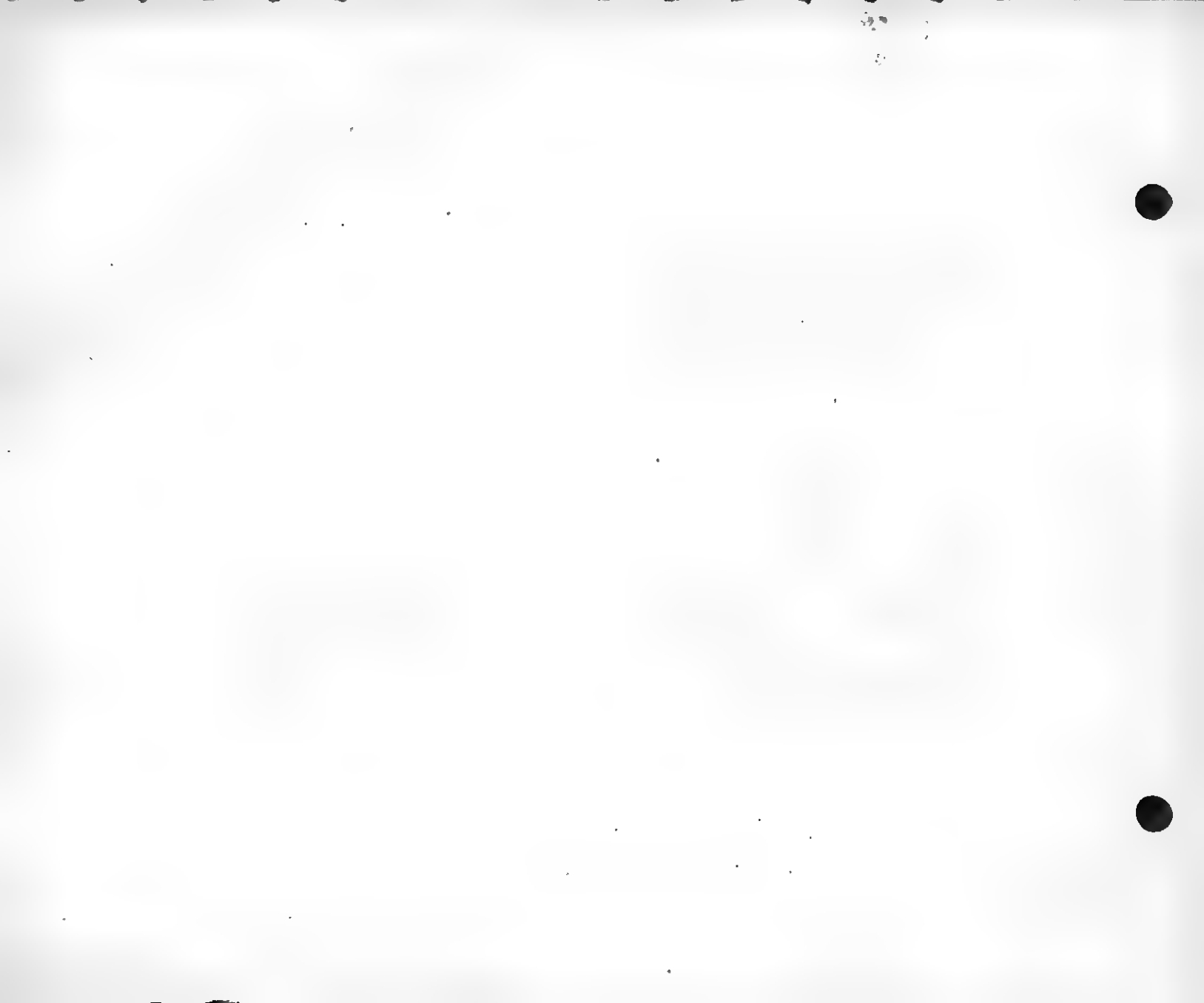
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

15008

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

15 11

1. PLACE OF DEATH a. COUNTY Baltimore		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Towson		c. LENGTH OF STAY IN 1b 2wks		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md.		b. COUNTY		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore		d. STREET ADDRESS 4210 Overton Avenue 21236		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) GREATER BALTIMORE MEDICAL CENTER															
3. NAME OF DECEASED (Type or print) First BERNARD		Middle ANTHONY		Last LEITKOWSKI		4. DATE OF DEATH Month 11		Day 13		Year 1967					
5. SEX Male		6. COLOR OR RACE Cauc.		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9/22/10		9. AGE (in years last birthday) 57 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10. IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pipefitter				10b. KIND OF BUSINESS OR INDUSTRY Coast Guard				11. BIRTHPLACE (County & State, or foreign country) New London, Conn.				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Unknown Leitkowski								14. MOTHER'S MAIDEN NAME Unknown							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes				16. SOCIAL SECURITY NO. 1934-1936				17. INFORMANT Mrs Frances J. Leitkowski				Address 4210 Overton Avenue			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Brain metastasis and pneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cancer of lung DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)															
INTERVAL BETWEEN ONSET AND DEATH 1 year															
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>															
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 9/22, 1967, to 11/13, 1967, that (I) (we) last saw the deceased alive on 11/13/1967, and that death occurred at 9:30 a.m. from the causes and on the date stated above.															
22a. SIGNATURE [Signature] 22b. DATE SIGNED 11/13/67															
22c. PHYSICIAN'S NAME (Type) Rudiger Breitenecker, M. D.				22d. ADDRESS Greater Baltimore Medical Center				22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>							
23a. BURIAL CREMATION REMOVAL (Specify) Burial				23b. DATE THEREOF 11-16-1967				23c. NAME OF CEMETERY OR CREMATORY Baltimore Nat'l Cemetery				23d. LOCATION (City, town or county) (State) Baltimore Md.			
24. FUNERAL DIRECTOR Lassabon Funeral Home				ADDRESS 2701 Belair Rd				25a. REC'D BY REGISTRAR NOV 15 1967				25b. REGISTRAR'S SIGNATURE [Signature]			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

<div>15009</div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> <div>CERTIFICATE OF DEATH</div> <div>15012</div>									
1. PLACE OF DEATH a. COUNTY <b>3A110</b> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>MD.</b> b. COUNTY				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>STEVENSON</b>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>STEVENSON</b>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>VILLA JULIE</b>					d. STREET ADDRESS <b>VALLEY RD.</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>SISTER ANTONIA SH. (LEAVEY)</b>					4. DATE OF DEATH Month <b>NOV.</b> Day <b>2</b> Year <b>19 67</b>				
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JAN. 1, 1885</b>		9. AGE (In years last birthday) <b>82 yrs</b>		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>TEACHER</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>RELIGIOUS</b>		11. BIRTHPLACE (County & State, or foreign country) <b>MASS.</b>			12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>PATRICK LEAVEY</b>					14. MOTHER'S MAIDEN NAME <b>MARY ELLEN MALONE</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT <b>Pat. Bernardine - Valley Julie</b> Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Crown Aneurysm</b> DUE TO (b) <b>arterosclerotic cardiac vascular disease</b> DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								INTERVAL BETWEEN ONSET AND DEATH <b>Months</b> <b>years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <b>1963</b> to <b>Nov 2, 1967</b> , that (I) (we) last saw the deceased alive on <b>10-28-1967</b> , and that death occurred at <b>2 A</b> M, from causes and on the date stated above.									
22a. SIGNATURE <b>Harold H. Burns</b>					M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>			22b. DATE SIGNED <b>11-3-1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>HAROLD H. BURNS</b>					22d. ADDRESS <b>8106 HARFORD Rd. Balt. Md.</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <b>11-4-67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Trinity Cem.</b>			23d. LOCATION (City or Town) (County) (State) <b>Dechster Md.</b>		
24. FUNERAL DIRECTOR <b>Farley Cronan B. H. Catorville Ind.</b>					25a. REC'D BY REGISTRAR DATE <b>NOV 6 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		





MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15006

15009

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by the Medical Examiner. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH  
a. COUNTY BALTO. MARYLAND  
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TOWSON  
c. LENGTH OF STAY in hour  
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) ST JOSEPH HOSPITAL

2. USUAL RESIDENCE (When deceased lived. If institutions, Residence before admission)  
a. STATE MD. b. COUNTY BALTO.  
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TIMONIDIST  
d. STREET ADDRESS 10 Yorkview Dr.

3. NAME OF DECEASED (Type or print) ROBERT EDWARDS LEE SR  
4. DATE OF DEATH NOV. 30 1967  
5. SEX Male 6. COLOR OR RACE White 7. MARRIED ☒ NEVER MARRIED ☐ 8. DATE OF BIRTH Sept. 14, 1906  
9. AGE (In years last birthday) 61 yrs IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min

10b. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plant Operator  
11. BIRTHPLACE (State or foreign country) Maryland  
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Wm. K. Lee Sr.  
14. MOTHER'S MAIDEN NAME Elizabeth Tucker

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No  
16. SOCIAL SECURITY NO 218-32-0868  
17. INFORMANT Mrs. Anna Virginia Lee Address 10 Yorkview Dr. 21093

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))  
PART DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION  
42:1 DUE TO  
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.  
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  
20c. TIME OF INJURY Month, Day, Year 19 20d. INJURY OCCURRED While at work ☐ Not While at work ☐  
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☒ and in my opinion death resulted from Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE William A. Pursbury CHIEF MEDICAL EXAMINER ☐  
EXAMINER'S NAME (Type) William A. Pursbury M.D. ASSISTANT MEDICAL EXAMINER ☐  
DEPUTY MEDICAL EXAMINER ☒ DATE SIGNED 11/30/67  
Address (Street, city, town, or county) Timonidist

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF 12/4/67 22c. NAME OF CEMETERY OR CREMATORY Jessop Cemetery 22d. LOCATION (City, town, or country) (State) Cockeysville, Md.

23. FUNERAL DIRECTOR Wm. Cook-Brooks ADDRESS Towson 1050 York Rd. 21204

24a. REC'D BY REG STRAR DEC 5 1967 24b. REGISTRAR'S SIGNATURE Charles Jones



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1 PLACE OF DEATH a COUNTY <u>BALTIMORE</u> MARYLAND					2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>MD.</u> b COUNTY <u>✓</u>				
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>			c LENGTH OF STAY IN IS <u>5 yrs</u>		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u>				
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>SHADY NOOK NURSING HOME</u>					d. STREET ADDRESS <u>821 N. WOODINGTON RD.</u>				e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3 NAME OF DECEASED (Type or print) <u>HARRY F. LEONARD.</u>					4. DATE OF DEATH Month <u>NOV.</u> Day <u>19</u> Year <u>1967</u>				
5 SEX <u>M</u>	6 COLOR OR RACE <u>W</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>FEB. 20, 1888</u>		9 AGE (In years lost birthday) <u>79</u> yrs	IF UNDER 1 YEAR Months <u>7</u> Days <u>9</u>		IF UNDER 24 HRS Hours <u>19</u> Min <u>67</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SHIP CLERK</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>D. O. R. R.</u>		11 BIRTHPLACE (County & State, or foreign country) <u>MD</u>			12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>WILLIAM LEONARD</u>					14. MOTHER'S MAIDEN NAME <u>MARY E.</u>				
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service)			16. SOCIAL SECURITY NO. <u>705-05-3012</u>		17. INFORMANT Address <u>Mrs John C Ward - 1241 Newfield Ave</u>				
18 CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY <u>4221</u> IMMEDIATE CAUSE (a) <u>arteriosclerotic cardiovascular disease</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>hypertension</u> (c) <u>myocardial infarction</u>									INTERVAL BETWEEN ONSET AND DEATH <u>4 yrs</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part or Part II of item 18)						
20c TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)		
21 I certify that (I) (the hospital) attended the deceased from <u>June 20</u> , 19 <u>63</u> , to <u>Nov 19</u> , 19 <u>67</u> , that (I) ( <del>we</del> ) last saw the deceased alive on <u>Nov 18</u> , 19 <u>67</u> , and that death occurred at <u>1:45 AM</u> , from causes and on the date stated above									
22a. SIGNATURE <u>John A. Nesbitt, Jr., M.D.</u>					ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>John A. Nesbitt, Jr., M.D.</u>					22d ADDRESS <u>1009 Frederick Road</u>				
23a BURN, CREMATION, REMOVAL (Specify)			23b. DATE THEREOF <u>11-22-67</u>		23c NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cem.</u>		23d LOCATION (City or Town) (County) (State) <u>Woodlawn Md.</u>		
24 FUNERAL DIRECTOR <u>Farley Lanning B.F.N. Catonsville, Md.</u>					25a. REC'D BY REGISTRAR DATE <u>NOV 24 1967</u>		25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15014

1 PLACE OF DEATH a. COUNTY <b>Baltimore</b>		2. USUAL RESIDENCE (Where deceased lived if instit on Residence before adm ssion) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mount Wilson</b>		c. LENGTH OF STAY IN tb <b>9 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Mount Wilson State Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <b>KENNETH MARSHALL LEONARD</b>		4 DATE OF DEATH Month <b>11</b> Day <b>18</b> Year <b>1967</b>	
5 SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>2.15.1899</b>
9 AGE (In years last birthday) yrs <b>68</b>		10. IF UNDER 1 YEAR Months <b>11</b> Days <b>18</b> Hours <b>19</b> Min <b>67</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Waterman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Seaford</b>	
11 BIRTHPLACE (County & State, or foreign country) <b>Deal Island, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13 FATHER'S NAME <b>WALTER C. LEONARD</b>		14 MOTHER'S MAIDEN NAME <b>CYNTHIA WINDSOR</b>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16 SOCIAL SECURITY NO. <b>218-05-1061</b>	
17. INFORMANT <b>Mount Wilson State Hospital records</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH CAUSED BY IMMEDIATE CAUSE (a) <b>Far advanced pulmonary tuberculosis</b> DUE TO (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		INTERVAL BETWEEN ONSET AND DEATH <b>over 1 yr.</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Carcinoma of lower lip</b>			
19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>11-9</b> , 19 <b>67</b> , to <b>11-18</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>11-18</b> , 19 <b>67</b> , and that death occurred at <b>6:30 A.M.</b> from causes and on the date stated above.			
22a. SIGNATURE <b>W. Newcomer</b>		22b. DATE SIGNED <b>11-18-1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>William Newcomer, M.D.</b>		22d. ADDRESS <b>Mount Wilson, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or town) (County) (State)
<b>BURIED</b>	<b>NOV. 20-1967</b>	<b>ST. JOHN'S CEMETERY</b>	<b>Deal Island Som Md.</b>
24 FUNERAL DIRECTOR <b>Leroy G Webster Princess Anne</b>		25a. REC'D BY REGISTRAR <b>DATE NOV 22 1967</b>	
		25b. REGISTRAR'S SIGNATURE <b>John Charles Judge</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR #15  
2DM 1/65

<div style="text-align: center;"> <b>MARYLAND STATE DEPARTMENT OF HEALTH</b>  <b>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</b>  <b>CERTIFICATE OF DEATH</b> </div>									
<b>1. PLACE OF DEATH</b> a. COUNTY <b>BALTIMORE</b> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>GREATER BALTIMORE MED. CENTER</b>					<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <b>PA.</b> b. COUNTY c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>STATE COLLEGE</b> d. STREET ADDRESS <b>451 E. HAMILTON AVE.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
<b>3. NAME OF DECEASED</b> (Type or print) <b>EUGENIA NMN LESTER</b> <b>5. SEX</b> <b>F</b> <b>6. COLOR OR RACE</b> <b>CAU</b> <b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			<b>4. DATE OF DEATH</b> <b>NOV. 22 1967</b> <b>8. DATE OF BIRTH</b> <b>9-10-02</b> <b>9. AGE</b> (In years last birthday) <b>65</b> yrs. IF UNDER 1 YEAR: Months Days Hours Min. IF UNDER 24 HRS.						
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>FARMVILLE, VA.</b> <b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>			<b>13. FATHER'S NAME</b> <b>THOMAS N. POTTS (DEC)</b> <b>14. MOTHER'S MAIDEN NAME</b> <b>Addie Parsons</b> <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>No</b> (If yes give war or dates of service) <b>16. SOCIAL SECURITY NO.</b> <b>188-36-5426</b> <b>17. INFORMANT</b> <b>John Campbell Lester</b> Address <b>451 E. Hamilton Ave.</b>						
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>RADIATION PNEUMONIA</b> (b) <b>IRRADIATION THERAPY</b> (c) <b>SQUAMOUS CELL CA OF FACE</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <b>20c. TIME OF INJURY</b> Month, Day, Year <b>19</b> Hour a.m. p.m. <b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town) (County) (State)</b>				<b>21. I certify that (I) (this hospital) attended the deceased from</b> <b>11-14-67</b> <b>19</b> , to <b>11-22-67</b> , that (I) (we) last saw the deceased alive on <b>11/22</b> <b>1967</b> , and that death occurred at <b>11:30 AM</b> , from the causes and on the date stated above.					
<b>22a. SIGNATURE</b> <b>Dr. Eduardo Canilang</b> M.D. <b>22c. PHYSICIAN'S NAME (Type)</b> <b>DR. EDUARDO CANILANG</b>				<b>22b. DATE SIGNED</b> <b>11/22/67</b> <b>22d. ADDRESS</b>					
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>		<b>23b. DATE THEREOF</b> <b>11/24/67</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Naval Academy Cem</b>		<b>23d. LOCATION (City, town or county) (State)</b> <b>Annapolis, Md.</b>			
<b>24. FUNERAL DIRECTOR</b> <b>Wm. J. Tichner Sons Balto., Md.</b> ADDRESS				<b>25a. REC'D BY REGISTRAR</b> <b>NOV 29 1967</b> <b>25b. REGISTRAR'S SIGNATURE</b> <b>J. Charles Judge</b>					



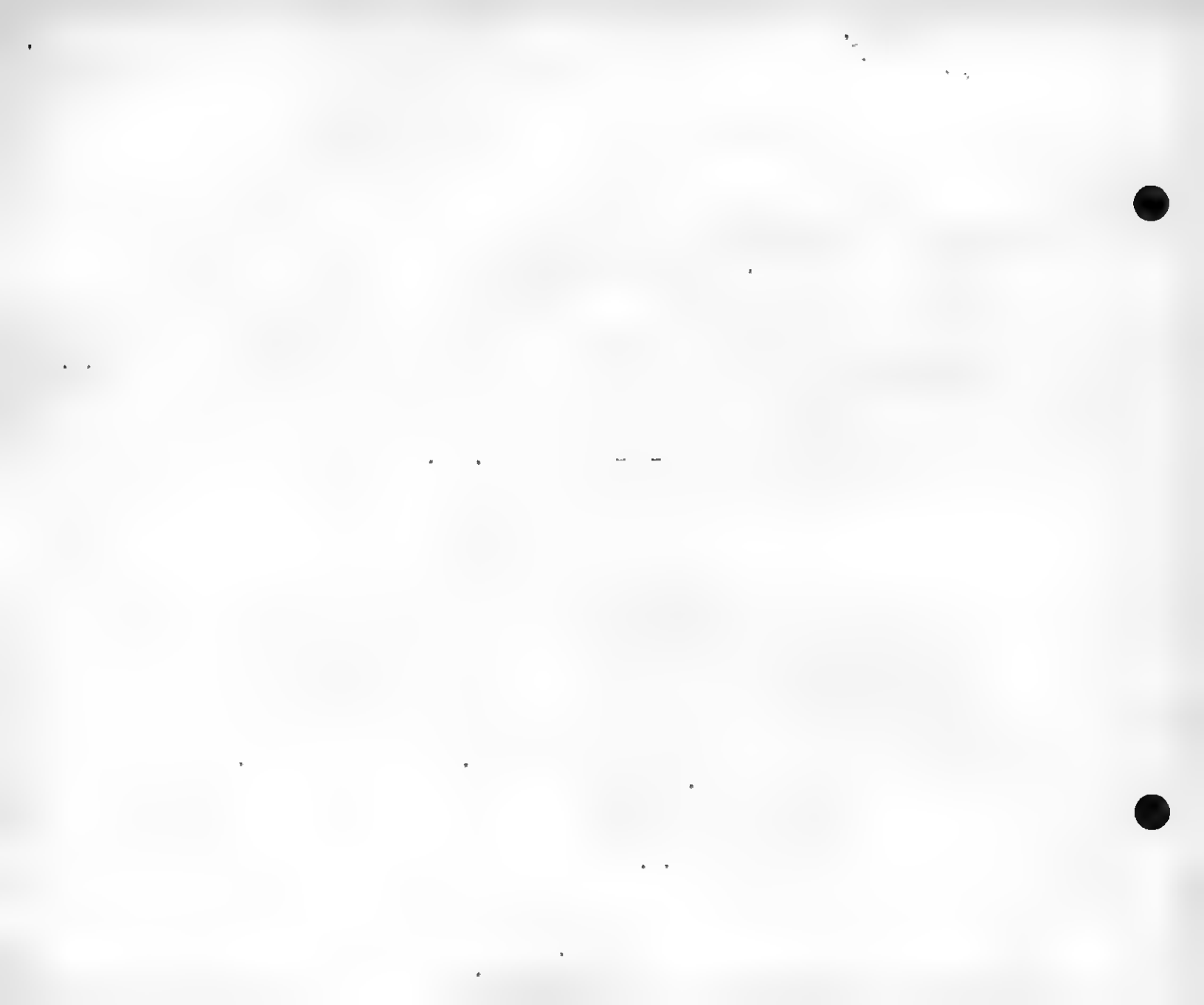


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

15013				DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				15016			
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>_____</b>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>		c. LENGTH OF STAY IN lb <b>14 Days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Veterans Administration Hospital</b>				d. STREET ADDRESS <b>1148 Hull Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>ZEGMUNT F. LESZYNSKI (LESZCZYNSKI)</b>				4. DATE OF DEATH Month <b>NOVEMBER</b> Day <b>29</b> Year <b>67</b>							
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3/9/24</b>		9. AGE (n years last birthday) <b>43</b> yrs	IF UNDER 1 YEAR Months <b>_____</b> Days <b>_____</b> Hours <b>_____</b> Min. <b>_____</b>					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Long Shoreman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Shipping</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>					
13. FATHER'S NAME <b>FRANK LESZCZYNSKI</b>				14. MOTHER'S MAIDEN NAME <b>KATHERINE PONIEWAZ</b>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>Yes WW II</b>		16. SOCIAL SECURITY NO <b>216-18-6113</b>		17. INFORMANT Address <b>Clin.Rec. VA Hospital, Fort Howard, Maryland</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PULMONARY EMBOLISM</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) <b>CONGESTIVE HEART FAILURE</b> DUE TO (c) <b>RHEUMATIC HEART DISEASE</b>						INTERVAL BETWEEN ONSET AND DEATH <b>3 Days</b> <b>3 Weeks</b> <b>YEARS</b>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>Nov. 15</b> , 19 <b>67</b> , to <b>Nov. 29</b> , 19 <b>67</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>Nov. 29</b> , 19 <b>67</b> , and that death occurred at <b>1:45 PM</b> from causes and on the date stated above.											
22a. SIGNATURE <b>Ahmed Kutty</b>				M.D. ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>11/29/67</b>					
22c. PHYSICIAN'S NAME (Type) <b>AHAMED KUTTY, M.D.</b>				22d. ADDRESS <b>VA HOSPITAL, FORT HOWARD, MARYLAND</b>							
23a. BURIAL, CREMATION, OR REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12/2/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Holy Rosary Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Maryland</b>					
24. FUNERAL DIRECTOR <b>Stevens Funeral Home</b>		ADDRESS <b>1501 E. Fort Ave Baltimore, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>DEC 1 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles J. [Signature]</b>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

15014

8 Maryland State Department of Health  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
Item 4 Film G-7 1-7-67  
**CERTIFICATE OF DEATH**

15017

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>Maryland</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>8yr5mth4dys</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>SPRING GROVE STATE HOSPITAL</b>		e. STREET ADDRESS <b>1632 RUXTON AVENUE</b> <b>4203 LIBERTY HEIGHTS AVENUE</b>	
3. NAME OF DECEASED (Type or print) First <b>Sarah</b> Middle <b>Levin</b> Last <b>Levin</b>		4. DATE OF DEATH Month <b>November</b> Day <b>15</b> Year <b>1967</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JUN 28 1911</b>
9. AGE (In years and birthday) <b>56 75 yrs</b>		10. IF UNDER 1 YEAR Months <b>11</b> Days <b>15</b> Hours <b>15</b> Min <b>00</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>AT HOME</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Maryland BALTIMORE</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>David KOENIGSBERG</b>		14. MOTHER'S MAIDEN NAME <b>Carrie GLASSNER</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>216-07-3561</b>	
17. INFORMANT <b>SAUL KOENIGSBERG, 2607 CVL BURY AVENUE</b> <b>Records SPRING GROVE STATE HOSPITAL</b>		18. ADDRESS	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b> DUE TO (b) <b>Arteriosclerotic Cardiovasc. disease.</b> DUE TO (c) <b>Lobar Pneumonia.</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that (X) (this hospital) attended the deceased from <b>June 4, 1959 to Nov 15, 1967</b> , that (I) (we) last saw the deceased alive on <b>Nov 15, 1967</b> , and that death occurred at <b>3:25 p.m.</b> , from causes and on the date stated above	
22a. SIGNATURE <b>Narciso W. Carmona M.D.</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>NARCISO W. CARMONA</b>		22d. ADDRESS <b>SPRING GROVE STATE HOSPITAL</b> <b>Baltimore, Maryland 21228</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>11-16-67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>HEBREW YOUNG MENS</b>	23d. LOCATION (City or Town) (County) (State) <b>BALTIMORE, MARYLAND</b>
24. FUNERAL DIRECTOR <b>SOL LEVINSON &amp; BROS. INC., 6010 REISTERSTOWN ROAD</b>		25a. REC'D BY REGISTRAR <b>NOV 17 1967</b>	25b. REGISTRAR'S SIGNATURE <b>William J. Judge</b>



DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

15015

10-18

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Baltimore</u> <b>MARYLAND</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>RANDALLSTOWN</u> c. LENGTH OF STAY IN TB d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Baltimore County General</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>2914 Smith Ave</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Solomon</u> Middle <u>NMI</u> Last <u>Levin</u>		<b>4. DATE OF DEATH</b> Month <u>11</u> Day <u>9</u> Year <u>1967</u>	
<b>5. SEX</b> <u>MALE</u>		<b>6. COLOR OR RACE</b> <u>WHITE</u>	
<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>XXXXXX/XX/XX</u>	
<b>9. AGE</b> (In years last birthday) <u>180</u>		<b>10. IF UNDER 1 YEAR</b> Months <u>  </u> Days <u>  </u>	
<b>11. IF UNDER 24 HRS.</b> Hours <u>  </u> Min. <u>  </u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>BARBER</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>SELF EMPLOYED</u>	
<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>RUSSIA</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>	
<b>13. FATHER'S NAME</b> <u>UNKNOWN</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>LEAH ?</u>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>NO</u>		<b>16. SOCIAL SECURITY NO.</b> <u>212-30-8785</u>	
<b>17. INFORMANT</b> <u>MR. BERNARD LEVIN, 617 LEAFYDALE TPR. #8</u>		<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).)	
<b>PART I. DEATH WAS CAUSED BY:</b> IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <u>Chronic lung disease - bronchiectasis - Pulmonary emphysema</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I.</b>			
<u>Interosclerotic Heart Disease</u>		<u>Pulmonary edema</u>	
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18)	
<b>20c. TIME OF INJURY</b> Month, Day, Year <u>19</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b>	
<b>20g. (County)</b>		<b>20h. (State)</b>	
<b>21. I certify that (I) (this hospital) attended the deceased from <u>11/2</u> to <u>11/9</u>, 19<u>67</u>, that (I) (we) last saw the deceased alive on <u>11/9</u>, 19<u>67</u>, and that death occurred at <u>9:30</u> AM, from the causes and on the date stated above.</b>			
<b>22a. SIGNATURE</b> <u>[Signature]</u>		<b>22b. DATE SIGNED</b>	
<b>22c. PHYSICIAN'S NAME (Type)</b> <u>ISABELITA Y. CORDOBA</u>		<b>22d. ADDRESS</b> <u>Balto County General</u>	
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>BURIAL</u>		<b>23b. DATE THEREOF</b> <u>11-10-67</u>	
<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>WORKMENS CIRCLE</u>		<b>23d. LOCATION (City, town or county)</b> <u>BALTIMORE, MARYLAND</u>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b>		<b>25a. REC'D BY REGISTRAR</b> <u>NOV 13 1967</u>	
<b>25b. REGISTRAR'S SIGNATURE</b> <u>[Signature]</u>		<b>25c. ADDRESS</b>	

SOL LEVINSON & BROS. INC., 6010 REISTERSTOWN ROAD

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15019

SS.#

R15058335

## CERTIFICATE OF DEATH

15019

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Reisterstown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Reisterstown</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>3 Sunnybing Drive</u>		d. STREET ADDRESS <u>3 Sunnybing Drive</u>	
3 NAME OF DECEASED (Type or print) First Middle Last <u>RALPH S. LEWIS</u>		4 DATE OF DEATH Month Day Year <u>Jan 1 1967</u>	
5 SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 17, 1883</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>construction</u>	9 AGE (in years last birthday) <u>83</u> yrs
11. BIRTHPLACE (County & State, or foreign country) <u>CONWAY, SOUTH CAROLINA</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Thomas Lewis</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Adeline Session</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16 SOCIAL SECURITY NO. <u>R15-05 8335</u>	
17 INFORMANT <u>Residence shown - alone</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> DUE TO (b) <u>Atherosclerosis - hypertension</u> DUE TO (c) <u>5 yrs</u>		INTERVAL BETWEEN ONSET AND DEATH <u>36 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> (Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)		20g. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from <u>12-1-</u> , 19 <u>67</u> to <u>1-1-</u> , 19 <u>67</u> , that (I) <u>was</u> last saw the deceased alive on <u>11-1-</u> , 19 <u>67</u> , and that death occurred at <u>3P</u> M, from causes on and on the date stated above.			
22a. SIGNATURE <u>James B. Saffell</u>		22b. DATE SIGNED <u>11-3-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>James B. Saffell MD</u>		22d. ADDRESS <u>Reisterstown, Md</u>	
23a. BURIAL-CREMATATION, REMOVAL (Specify)	23b. DATE THEREOF <u>11-4-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Savage Cemetery</u>	23d. LOCATION (City or town) (County) (State) <u>Savage, Howard Md</u>
24 FUNERAL DIRECTOR <u>de Witt Concedean Laurel Md</u>		25a. REC'D BY REGISTRAR DATE <u>NOV 6 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>James Judge</u>			





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4, which should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>		c. LENGTH OF STAY IN TB <b>10 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Greater Baltimore Medical Center</b>		d. STREET ADDRESS <b>225 Hopkins Rd</b>	
3. NAME OF DECEASED (Type or print) <b>ERNEST MAX LINDNER</b>		4. DATE OF DEATH <b>11 29 19 67</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>CAU</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11-15-98</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>—</b>	
11. BIRTHPLACE (County & State or foreign country) <b>Richmond, VA.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>FRANK LINDNER</b>		14. MOTHER'S MAIDEN NAME <b>Mary Hattenbacher</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO <b>705-07-4473</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PORTAL VEIN THROMBOSIS</b> DUE TO (b) <b>—</b> DUE TO (c) <b>—</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <b>12 HRS</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c) <b>CIRRHOSIS OF LIVER</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (H) (this hospital) attended the deceased from <b>11-19-1967</b> to <b>11-29-1967</b> , that (H) (we) last saw the deceased alive on <b>11-29-1967</b> , and that death occurred at <b>7:35 AM</b> , from causes and on the date stated above			
22a. SIGNATURE <b>P. Chaudhuri</b>		22b. DATE SIGNED <b>11-29-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>P. CHAUDHURI</b>		22d. ADDRESS <b>GREATER BALTIMORE MED. CTR.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>12/2/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Moreland Memorial</b>	23d. LOCATION (City or Town) (County) (State) <b>Balto. County, Md.</b>
24. FUNERAL DIRECTOR <b>Mitchell-Wiedefeld Home</b> ADDRESS <b>6500 York Rd. Balto., Md. 21212</b>		25a. REC'D BY REGISTRAR <b>DEC 7 1967</b> 25b. REGISTRAR'S SIGNATURE <b>J. Santos Judge</b>	



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15-20

FOR STATE  
HEALTH REP.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <b>Dundalk</b>		c. LENGTH OF STAY IN 1b <b>26 Years</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>5 Graywood Road</b>		d. STREET ADDRESS <b>5 Graywood Road</b>	
3 NAME OF DECEASED (Type or print) <b>Harold</b>		4 DATE OF DEATH Month <b>November</b> Day <b>21</b> Year <b>1967</b>	
5 SEX <b>Male</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>Aug. 17, 1906</b>
9 AGE (In years lost birthday) <b>61</b> yrs		IF UNDER 1 Year Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Repairman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>C. S. Bowen &amp; Co.</b>	
11 BIRTHPLACE (State or foreign country) <b>West Virginia</b>		12 CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13 FATHER'S NAME <b>Namon S. Locke</b>		14 MOTHER'S MAIDEN NAME <b>Theodosia E. Hooper</b>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16 SOCIAL SECURITY NO <b>236-03-3635</b>	
17 INFORMANT (Wife) <b>Mrs. Mildred Locke, 5 Graywood Rd. Dundalk,</b>		Address <b>Md. 21222</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY <b>177X</b> IMMEDIATE CAUSE (a) <b>Cancer of Prostate Gland</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <b>Metastatic Spread.</b> DUE TO (c)			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Interval between onset and death</b>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, off ice bldg. etc.)	20f. (City or town) (County) State
21 I certify that I took charge of the remains described above held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Theodore C. Patterson</b>		M.D. <b>Theodore C. Patterson</b>	
EXAMINER'S NAME (Type) <b>Theodore C. Patterson</b>		22. DATE SIGNED <b>11/21/67</b>	
23a. BURIAL CREMATION REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>11/24/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Meadowridge Memorial Pk.</b>	23d. LOCATION (City or town) County State <b>Dorsey, Md.</b>
24 FUNERAL DIRECTOR <b>John J. Duda, 7922 Wise Ave. Dundalk, Md.</b>		25a. REC'D BY REGISTRAR <b>NOV 24 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>John J. Duda</b>			



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15019

15022

FOR STATE  
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sparrows Point</b>		c. LENGTH OF STAY IN TB	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>516 D Street</b>		e. STREET ADDRESS <b>516 D Street</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Maude S. Loftus</b>		4. DATE OF DEATH Month Day Year <b>November 22 1967</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 28, 1892</b>
9. AGE (In years last birthday) <b>75 yrs</b>		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Milliner-ret.</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>James W. Loftus</b>		14. MOTHER'S MAIDEN NAME <b>Anne C. Hilbinger</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No.</b>		16. SOCIAL SECURITY NO <b>217-54-3742</b>	
17. INFORMANT <b>Miss Margaret Loftus</b>		Address <b>516 D. St. 21219</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY <b>A-5-C-V-DISEASE</b> <b>7221</b> IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <b>No Inj</b>	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		22. DATE SIGNED <b>11/24/67</b>	
ACTUAL SIGNATURE <b>M.D. Davis</b> EXAMINER'S NAME (Type) <b>M.D. Davis, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town or county) <b>6800 Morningside Rd.</b>	
23a. PURCHASE OF CREMATION REMOVAL (Specify) <b>Cremation</b>	23b. DATE THEREOF <b>Nov. 25, 1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Greenmount Cemetery Baltimore, Md.</b>	
24. FUNERAL DIRECTOR <b>Ullrich Funeral Home Dundalk, Md.</b>		25a. RECEIVED BY REGISTRAR <b>NOV 28 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15020

CERTIFICATE OF DEATH

15023

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>BALTO</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>PARKVILLE</u>		c. LENGTH OF STAY IN 1b <u>8 years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkville</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>2812 Second Ave</u>				d. STREET ADDRESS <u>2812 Second Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>EMMA</u> Middle <u>LOSKA</u> Last <u>LOSKA</u>				4. DATE OF DEATH Month <u>Nov</u> Day <u>28</u> Year <u>1967</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 23 1896</u>		9. AGE (In years lost birthday) yrs. <u>71</u>	F UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>ALBERT Se. Fert</u>				14. MOTHER'S MAIDEN NAME <u>ALBERTINE Ph. Lipp</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO <u>  </u>		17. INFORMANT Address <u>Mrs. ERNA Kuhn 2812 Second Ave</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE MYOCARDIAL INFARCTION</u> <u>4301</u> DUE TO (b) <u>ARTERIOSCLEROTIC HEART DISEASE</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO (c) <u>ESSENTIAL HYPERTENSION</u> INTERVAL BETWEEN ONSET AND DEATH <u>12 HOURS</u> <u>2 1/2 YEARS</u> <u>10 YRS</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>7/16</u> , 19 <u>65</u> to <u>Nov-28</u> , 19 <u>67</u> , that (I) <u>  </u> saw the deceased alive on <u>Nov-3</u> , 19 <u>67</u> , and that death occurred at <u>12 PM</u> , from causes and on the date stated above							
22a. SIGNATURE <u>John H. Hirschfeld, MD</u>				22b. DATE SIGNED <u>Dec 1 1967</u>		22c. PHYSICIAN'S NAME (Type) <u>JOHN H. HIRSCHFELD, MD.</u>	
22d. ADDRESS <u>6919 Harford road</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>12-1-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Parkwood Cemetery</u>		23d. LOCATION (City or town) (County) (State) <u>BALTO MD</u>	
24. FUNERAL DIRECTOR <u>CHAS. F. EVANS &amp; Son</u>		ADDRESS <u>8802 Harford Rd</u>		25a. REC'D BY REGISTRAR <u>DEC 4 1967</u>		25b. REGISTRAR'S SIGNATURE <u>John J. Judge</u>	





# FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Item 18. PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (3)  
6M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Woodlawn</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Woodlawn Baltimore 21207</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>934 Masfield Road</u>		d. STREET ADDRESS <u>934 Masfield Road</u>	
3. NAME OF DECEASED (Type or print) First <u>Clement</u> Middle <u>B.</u> Last <u>Lovett</u>		4. DATE OF DEATH Month <u>Nov.</u> Day <u>4</u> Year <u>1967</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 4, 1906</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Gas and Electric Co.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	9. AGE (In years last birthday) yrs <u>61</u>
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>David Lovett</u>		14. MOTHER'S MAIDEN NAME <u>Matilda Binger</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO <u>212055156</u>	
17. INFORMANT <u>Mrs Martha A. Lovett</u>		Address <u>same</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY <u>4221</u> IMMEDIATE CAUSE (a) <u>Cardio - Vascular Disease</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO			INTERVAL BETWEEN ONSET AND DEATH <u> sudden</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS A TOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>J. N. Frederick</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>S. N. Frederick</u> M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		Address (Street, city, town, or county) <u>1311 Francis Ave</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	23b. DATE THEREOF <u>11-8-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Parkwood Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Md.</u>
24. FUNERAL DIRECTOR <u>Leonard J. Ruck, Inc Baltimore, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>NOV 6 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>J. N. Frederick</u>	

22. DATE SIGNED  
11/6/67



FOR STATE  
HEALTH DEPT.

15022

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15025

1 PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Essex</b>		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Edgemore</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>1637 Eastern Ave.</b>		d. STREET ADDRESS <b>7617 North Point Rd.</b>	
3. NAME OF DECEASED (Type or print) <b>Charles Mackey</b>		4. DATE OF DEATH Month <b>November</b> Day <b>27</b> Year <b>1967</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 12, 1892</b>
9. AGE (In years last birthday) <b>75</b> yrs		IF UNDER 1 YEAR Months _____ Days _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Strip Mill</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Bethlehem Steel Co.</b>	
11. BIRTHPLACE (State or foreign country) <b>Ohio</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>John Mackey</b>		14. MOTHER'S MAIDEN NAME <b>Sina Ernest</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO <b>213-07-2503</b>	
17. INFORMANT (Daughter) <b>Mrs. Virginia Walter, 6724 Woodley Rd.</b>		18. DUNDALK, Md. 21222	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY <b>4201</b> IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> DUE TO Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>A-S-C-V Disease</b> (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>—</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 8) <b>None</b>	
20c. TIME OF INJURY Month Day, Year Hour a.m. _____ p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg, etc.)	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Indetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>M.B. Davis</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> <b>6800 Morningside Rd.</b>	
EXAMINER'S NAME (Type) <b>Melvin B. Davis</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> <b>Dundalk,</b>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>M.D., Md. 21222</b>	
		Address (Street, city, town, or county) <b>11/28/67</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>11/30/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Bel Air Memorial Gardens</b>	23d. LOCATION (City or town) _____ (County) _____ (State) _____ <b>Bel Air, Md.</b>
24. FUNERAL DIRECTOR <b>John J. Duda, 7922 Wise Ave. Dundalk, Md.</b>		25a. RECEIVED BY REGISTRAR <b>NOV 29 1967</b>	
		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Page 1. Pages 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

15023

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15026

1 PLACE OF DEATH a COUNTY <b>Baltimore</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Edgemere</b>		c LENGTH OF STAY IN 1b <b>40 Years</b>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>7617 North Point Road</b>		e STREET ADDRESS <b>7617 North Point Road</b>	
3 NAME OF DECEASED (Type or print) <b>Nora Elizabeth Mackey</b>		4 DATE OF DEATH Month <b>November</b> Day <b>11</b> Year <b>1967</b>	
5 SEX <b>Female</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>Aug. 28, 1895</b>
9 AGE (In years, last birthday) <b>72</b> yrs		10 IF UNDER 1 YEAR Months <b>72</b> Days <b>0</b> Hours <b>0</b> Min <b>0</b>	
10a USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <b>Housewife</b>		10b KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (State or foreign country) <b>West Virginia</b>		12 CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13 FATHER'S NAME <b>Robert Taylor</b>		14 MOTHER'S M A D E N NAME <b>Eva Yancey</b>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16 SOCIAL SECURITY NO <b>213-07-2503B</b>	
17 INFORMANT (Daughter) <b>Mrs. Virginia Walter, 6724 Woodley Rd.</b>		18 DUNDALK, Md. 21222	
18 CAUSE OF DEATH (Enter on only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Acute Coronary Occlusion</b> DUE TO <b>HCVD</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour <b>19</b> p.m.		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Theodore C. Patterson</b> EXAMINER'S NAME (Type)		22. DATE SIGNED <b>11/11/67</b> 105 Main St. Dundalk, Md. 21222	
23a BURIAL OR CREMATION REMOVAL (Specify) <b>Burial</b>		23b DATE THEREOF <b>11/14/67</b>	
23c NAME OF CEMETERY OR CREMATORY <b>Bel Air Memorial Gardens</b>		23d LOCATION (City or Town) (County) (State) <b>Bel Air, Md.</b>	
24 FUNERAL DIRECTOR <b>John J. Duda, 7922 Wise Ave. Dundalk, Md.</b>		25a REC'D BY REGISTRAR DATE <b>NOV 14 1967</b>	
25b REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>GREATER BALTIMORE MEDICAL CENTER</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b> d. STREET ADDRESS <b>APT. 606 3900, N. CHARLES ST.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <b>EDYTHE</b> Middle <b>KAHN</b> Last <b>HANKO</b>			4. DATE OF DEATH Month <b>11</b> Day <b>24</b> Year <b>1967</b>						
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>CAUCASIAN</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7/28/1898</b>	9. AGE (In years last birthday) <b>69</b> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>RETAIL</b>		11. BIRTHPLACE (County & State, or foreign country) <b>BALTIMORE, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>HENRY B HANKO</b>			14. MOTHER'S MAIDEN NAME <b>SOPHIE KAHN</b>						
15. WAS DECEASED EVER IN U.S. ARMY OR NAVY? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>215-09-1383</b>		17. INFORMANT <b>MR. LEON M. KATZ, 6615 PARK HEIGHTS AVE. #1</b>		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4221 Arteriosclerotic cardiovascular disease</b> DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Subluxation of cervical spine with partial cord compression</b>									INTERVAL BETWEEN ONSET AND DEATH
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>due to osteoarthritis and osteoporosis</b>							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>11/20</b> , 19 <b>67</b> to <b>11/24</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>11/24</b> , 19 <b>67</b> , and that death occurred at <b>7:00</b> A.M. from the causes and on the date stated above.									
22a. SIGNATURE <b>Derek A. Bruce</b>				22b. DATE SIGNED <b>11/29/67</b>					
22c. PHYSICIAN'S NAME (Type) <b>DEREK A. BRUCE</b>		22d. ADDRESS <b>G. B. R. C.</b>		22e. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>11-26-67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>BALTIMORE HEBREW</b>		23d. LOCATION (City, town or county) (State) <b>BALTIMORE, MARYLAND</b>			
24. FUNERAL DIRECTOR <b>SOL LEVINSON &amp; BROS. INC., 6010 REISTERSTOWN RD.</b>		24b. ADDRESS <b>REISTERSTOWN RD.</b>		25a. REC'D BY REGISTRAR <b>NOV 28 1967</b>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

10



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 42 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15025

15028

1 PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Owings Mills</b>		c. LENGTH OF STAY IN 1b <b>17 months</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Rosewood State Hospital</b>		d. STREET ADDRESS <b>1715 Flora Lane</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Maria</b> First <b>-</b> Middle <b>-</b> Last <b>MARCELLO</b>		4. DATE OF DEATH Month <b>11</b> Day <b>21</b> Year <b>19 67</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12-26-65</b>
9. AGE (In years last birthday) <b>1 1/2 yrs</b>		10. IF UNDER 1 YEAR Months <b>1</b> Days <b>21</b>	11. IF UNDER 24 HRS Hours <b>21</b> Min <b>67</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Dependent</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>none</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Montgomery Co., Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Rudolph Marcello</b>		14. MOTHER'S MAIDEN NAME <b>Rose Miller</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO <b>none</b>	
17. INFORMANT <b>Rudolph Marcello</b> Address <b>1715 Flora Lane, S.D. Md.</b> <b>Rosewood Records, Owings Mills, Md. 21117</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cerebral insufficiency</b> DUE TO <b>Hydrocephalus, sever, 750ml. content</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>23 Mon</b> (c)		INTERVAL BETWEEN ONSET AND DEATH <b>23 Mon</b>	
PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Institutionalization 17 Mon. Mental retardation, sever</b>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part I of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (a) (this hospital) attended the deceased from <b>6/7</b> , 1966, to <b>11/21</b> , 1967, that (a) (we) last saw the deceased alive on <b>11/21</b> 19 67, and that death occurred at <b>2:50</b> <b>PM</b> from causes and on the date stated above			
22a. SIGNATURE <b>Richard A. Jones</b>		22b. DATE SIGNED <b>21 Nov 67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Richard A. Jones</b>		22d. ADDRESS <b>Rosewood State Hosp.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Funeral Director</b>		23b. DATE THEREOF <b>Nov. 24, 1967</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>C. Glen Carter</b>		23d. LOCATION (City or Town) (County) (State) <b>Silver Spring, Maryland</b>	
23e. ADDRESS <b>2414 Georgia Ave. Silver Spring, Md.</b>		25a. REC'D BY REGISTRAR <b>Charles Judge</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		DATE <b>NOV 24 1967</b>	



CERTIFICATE OF DEATH

15029

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, (Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CATONSVILLE</b>		c. LENGTH OF STAY IN 1b <b>143 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>SUMMIT NURSING HOME</b>				d. STREET ADDRESS <b>1004 UNIVERSITY PKWY</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <b>ADELAIDE COATES MATTHAI</b>				4 DATE OF DEATH Month <b>NOVEMBER</b> Day <b>28</b> Year <b>1967</b>			
5 SEX <b>F</b>	6 COLOR OR RACE <b>W</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>12/7/1885</b>		9 AGE (In years last birthday) yrs <b>81</b>	10 IF UNDER 1 YEAR Months Days Hours Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (County & State, or foreign country) <b>New York, N.Y.</b>		12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>H. Foster Coates</b>				14 MOTHER'S MAIDEN NAME <b>Adelaide Chester Kinsley</b>			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16 SOCIAL SECURITY NO <b>No</b>		17. INFORMANT <b>CHART</b> Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>After several the Cardiovascular</b> DUE TO <b>disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Coronary Heart failure</b> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c TIME OF INJURY Month, Day, Year Hour a.m. 19		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>7/8</b> , 19 <b>67</b> , to <b>Nov. 28</b> , 19 <b>67</b> that (I) (we) lost saw the deceased alive on <b>11/27</b> , 19 <b>67</b> , and that death occurred on <b>11/28</b> M, from causes and on the date stated above							
22a. SIGNATURE <b>Edmund Kasaitis</b> M.D.				ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b DATE SIGNED <b>11/28/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>EDMUND KASAITIS M.D.</b>				22d ADDRESS <b>1807 Frolick Road #28</b>			
23a BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b DATE THEREOF <b>11-30-67</b>		23c NAME OF CEMETERY OR CREMATORY <b>Druid Ridge</b>		23d LOCATION (City or Town) (County) (State) <b>Baltimore, Baltimore, Md.</b>	
24 FUNERAL DIRECTOR <b>Wm. Cook-Brooks Towson, Towson, Md.</b>				25a REC'D BY REGISTRAR <b>DEC 5 1967</b>		25b REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15027

15030

1 PLACE OF DEATH a COUNTY <b>BALTIMORE</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE <b>MARYLAND</b> b COUNTY	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>		c LENGTH OF STAY IN 1b <b>88 DAYS</b>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>VETERANS ADMINISTRATION HOSPITAL</b>		d STREET ADDRESS <b>2810 ALLENDALE ROAD</b>	
3 NAME OF DECEASED (Type or print) First <b>CHARLES</b> Middle <b>L</b> Last <b>MATTHEWS</b>		4 DATE OF DEATH Month <b>NOVEMBER</b> Day <b>7</b> Year <b>1967</b>	
5 SEX <b>MALE</b>	6 COLOR OR RACE <b>NEGRO</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>2/3/12</b>
9 AGE (in years birth day) yrs <b>55</b>		10 UNDER 1 YEAR Months Days Hours Min <b>55</b>	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LABORER</b>		10b KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (County & State or foreign country) <b>BALTIMORE, MARYLAND</b>		12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13 FATHER'S NAME <b>RAYMONS MATTHEWS</b>		14 MOTHER'S MAIDEN NAME <b>MALINDA GARDNER</b>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>YES WWII</b>		16 SOCIAL SECURITY NO <b>218 07 25 90</b>	
17 INFORMANT <b>CLINICAL RECORDS, VAH, FT. HOWARD, MD.</b>		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>CARCINOMA OF ESOPHAGUS</b> <b>150x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH <b>3 MONTHS</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f (City or town) (County) (State)	
21 I certify that (this hospital) attended the deceased from <b>AUG 11, 1967</b> , to <b>NOV 7, 1967</b> , that (we) last saw the deceased alive on <b>NOV 7, 1967</b> , and that death occurred at <b>3:50 AM</b> , from causes and on the date stated above.		22a SIGNATURE <b>Rodolfo G. Miro, M.D.</b>	
22b DATE SIGNED <b>11/7/67</b>		22c PHYSICIAN'S NAME (Type) <b>RODOLFO G. MIRO, M. D.</b>	
22d ADDRESS <b>VAH FORT HOWARD, MARYLAND</b>		22e ADDRESS	
23a BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b DATE THEREOF <b>11/13/67</b>	
23c NAME OF CEMETERY OR CREMATORY <b>BALTIMORE NATIONAL</b>		23d LOCATION (City or Town) (County) (State) <b>BALTIMORE, MARYLAND</b>	
23e ADDRESS <b>IAW FUNERAL HOME</b>		23f REC'D BY REGISTRAR <b>1967</b>	
23g REGISTRAR'S SIGNATURE <b>Charles Judge</b>		23h REGISTRAR'S SIGNATURE	

802 MADISON AVE. BALTIMORE, MD.



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VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15022

15 31

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u>		c. LENGTH OF STAY IN TB <u>1 week</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u>		d. STREET ADDRESS <u>2108 ERDMAN AVE</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>GREATER BALTIMORE MED CTR.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Thomas MAURO</u>		4. DATE OF DEATH Month <u>NOV.</u> Day <u>6</u> Year <u>1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>Cau</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-14-90</u>
9. AGE (In years last birthday) <u>77</u> yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED Plasterer</u>		11. BIRTHPLACE (Country & State, or foreign country) <u>ITALY</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME <u>UNKNOWN</u> Mauro	
14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO <u>087-00-3444</u>		17. INFORMANT <u>Patients' CHART</u> Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiovascular failure</u> DUE TO (b) <u>CD of the lungs with metastases</u> DUE TO (c) <u>lost</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Rat While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>10.31</u> , 19 <u>67</u> , to <u>11.6</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>11.6.67</u> 19 <u>67</u> , and that death occurred at <u>12:50 AM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Rah m. Basnie</u>		22b. DATE SIGNED <u>11.6.67</u>	
22c. PHYSICIAN'S NAME (Type) <u>G.B.M.C.</u>		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>11/9/67.</u>	23c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Md.</u>
24. FUNERAL DIRECTOR <u>Leonard J. Ruck, Inc. Balto. Md. 21214</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
25b. REGISTRAR'S SIGNATURE		DATE <u>NOV 6 1967</u>	





CERTIFICATE OF DEATH

15029

15032

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician  
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1 PLACE OF DEATH a COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cockeysville</u>		c. LENGTH OF STAY IN TB <u>3 yrs 8 mo</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Bonnie Blinka Masonic Home</u>		d. STREET ADDRESS <u>Box 283 Walnut Ave.</u>	
3 NAME OF DECEASED (Type or print) <u>Leah Belle MAYS</u>		4. DATE OF DEATH Month <u>11</u> Day <u>24</u> Year <u>1967</u>	
5 SEX <u>F</u>	6 COLOR OR RACE <u>W</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>1-8-1884</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	9 AGE (in years last birthday) <u>83 yrs</u>
11. BIRTHPLACE (County & State, or foreign country) <u>Marysville, Pa.</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13 FATHER'S NAME <u>Daniel T. Robinson</u>		14. MOTHER'S MAIDEN NAME <u>Lane Kurtz</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16 SOCIAL SECURITY NO <u>175-10-7017</u>	
17 INFORMANT <u>Mrs. Bertha Mays, Parkton, Md.</u>		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>1 Coronary artery occlusion</u> DUE TO (b) <u>3 Fractured Rt hip</u> DUE TO (c) <u>3, Anterior Wall Heart Disease</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (i) (this hospital) attended the deceased from <u>August 11, 1965</u> to <u>Nov 24, 1967</u> , that (i) (we) last saw the deceased alive on <u>Nov 24, 1967</u> , and that death occurred at <u>7:28 AM</u> , from causes on and on the date stated above			
22a SIGNATURE <u>J. Hamel MD.</u>		22b. DATE SIGNED <u>11/24/67</u>	
22c PHYSICIAN'S NAME (Type) <u>JAMSHID HAMEL</u>		22d ADDRESS <u>Cockeysville, MD MASONIC HOME</u>	
23a BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
<u>Burial</u>	<u>Nov. 28, 1967</u>	<u>Mt. Zion Cemetery</u>	<u>Freeland, Md.</u>
24 FUNERAL DIRECTOR <u>Joseph Kortenstern, New Freedom, Pa.</u>		25a REC'D BY REGISTRAR DATE <u>NOV 29 1967</u>	
		25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

15050

15'33

<b>1. PLACE OF DEATH</b> <b>a. COUNTY</b> <i>Baltimore</i> <b>MARYLAND</b> <b>b. CITY OR TOWN</b> (if outside corporate limits, write RURAL and give nearest town) <i>Timonium</i> <b>c. LENGTH OF STAY IN 1b</b> <i>Timonium</i> <b>d. NAME OF HOSPITAL OR INSTITUTION</b> (if not in hospital, give street address) <i>Box 1 adonia an' ien'er R d's</i>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) <b>a. STATE</b> <i>Maryland</i> <b>b. COUNTY</b> <i>Baltimore</i> <b>c. CITY OR TOWN</b> (if outside corporate limits, write RURAL and give nearest town) <i>Timonium</i> <b>d. STREET ADDRESS</b> <i>1 adonia an' ien'er R d's</i> <b>e. IS RESIDENCE ON A FARM?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <i>Martha E. Nays</i>			<b>4. DATE OF DEATH</b> Month <i>Nov</i> Day <i>8</i> Year <i>1967</i>				
<b>5. SEX</b> <i>Female</i>	<b>6. COLOR OR RACE</b> <i>White</i>	<b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <i>May 15, 1915</i>	<b>9. AGE</b> (In years last birthday) <i>52</i> yrs. <b>IF UNDER 1 YEAR</b> Months <i>0</i> Days <i>0</i> Hours <i>0</i> Min.	<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <i>housewife</i>		
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <i>housewife</i>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <i>none</i>	<b>11. BIRTHPLACE</b> (County & State, or foreign country) <i>Marland</i>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <i>USA</i>		
<b>13. FATHER'S NAME</b> <i>William M. Foster</i>			<b>14. MOTHER'S MAIDEN NAME</b> <i>Hannah Francis</i>				
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, No, or unknown) <i>no</i>		<b>16. SOCIAL SECURITY NO.</b> (If yes give war or dates of service) <i>none</i>	<b>17. INFORMANT</b> Address <i>Family records</i>				
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] <b>PART I. DEATH WAS CAUSED BY:</b> <b>IMMEDIATE CAUSE (a)</b> <i>arteriosclerotic Cardio Vascular Disease</i> <b>CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST.</b> (b) <i>none</i> (c) <i>none</i>							
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>							
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. <i>19</i> p.m. <i>19</i> <b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town) (County) (State)</b>							
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <i>MAY</i> , 1963, <b>to</b> <i>11/8/1967</i> , <b>that (I) (we) last saw the deceased alive on</b> <i>Oct 19, 1967</i> , <b>and that death occurred at</b> <i>10 A.M.</i> , <b>from the causes and on the date stated above.</b>							
<b>22a. SIGNATURE</b> <i>M. X. Quinn</i> <b>22b. DATE SIGNED</b> <i>11/9/67</i> <b>22c. PHYSICIAN'S NAME (Type)</b> <i>M. KEVIN QUINN MD</i> <b>22d. ADDRESS</b> <i>1927 York Rd, TIMONIUM, Md</i>							
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <i>Burial</i>		<b>23b. DATE THEREOF</b> <i>Nov. 10, 1967</i>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <i>Maple Chapel Cemetery</i>		<b>23d. LOCATION (City, town or county) (State)</b> <i>Timonium, Maryland</i>		
<b>24. FUNERAL DIRECTOR</b> <i>John Wynn's Sons, To son, Marland</i>			<b>25a. REC'D BY REGISTRAR</b> <i>Charles Judge</i> <b>25b. REGISTRAR'S SIGNATURE</b> DATE <i>NOV 16 1967</i>				



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VR A15 (4)  
25M 1/67

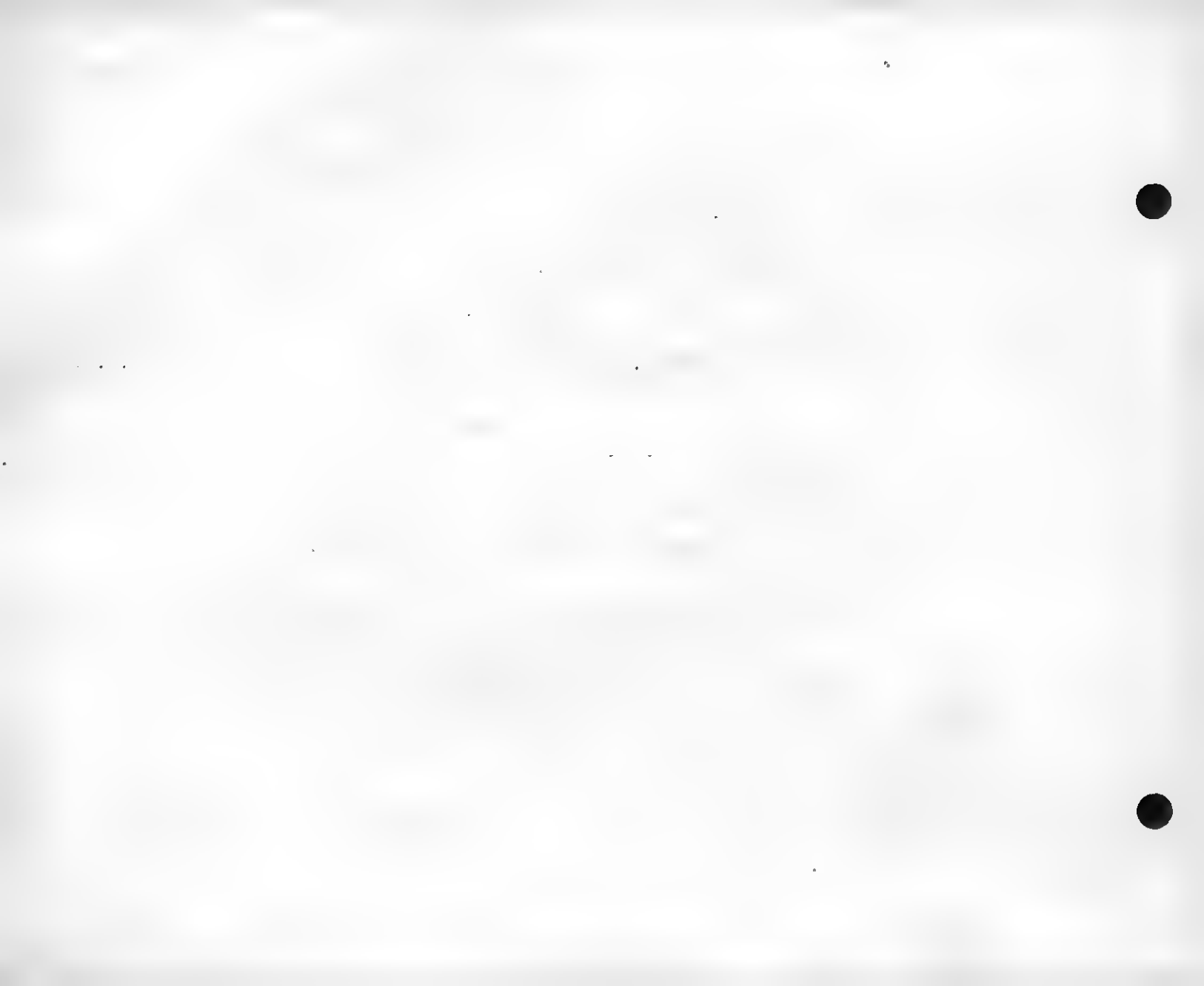
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15031

15034

1 PLACE OF DEATH a COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE <b>Maryland</b> b COUNTY	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c LENGTH OF STAY IN lb <b>Baltimore</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>House in the Pines Nursing Home</b>		d. STREET ADDRESS <b>1303 W. Cross Street</b>	
3 NAME OF DECEASED (Type or print) <b>John Jerome McAleer, Sr.</b>		4 DATE OF DEATH Month <b>November</b> Day <b>29</b> Year <b>1967</b>	
5 SEX <b>Male</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>8-17-1888</b>
9. AGE (In years last birthday) <b>79</b> yrs		IF UNDER 1 YEAR Months Days Hours Min	
10a USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) <b>Retired</b>		10b KIND OF BUSINESS OR INDUSTRY <b>Balto. Transit Co.</b>	
11 BIRTHPLACE (County & State, or foreign country) <b>Baltimore, Maryland</b>		12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Phillip McAleer</b>		14. MOTHER'S MAIDEN NAME <b>Katherine</b>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16 SOCIAL SECURITY NO <b>213-05-9981A</b>	
17 INFORMANT <b>Mrs. Mary C. Otterbein, 2707 Rittenhouse Ave.</b>		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Broncho-Pneumonia</b> DUE TO (b) <b>Arteriosclerotic Cardio-Vascular Disease</b> DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH <b>9 da.</b> <b>10 yrs.</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>10-31-</b> , 19 <b>67</b> , to <b>11-29</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>11-27</b> , 19 <b>67</b> , and that death occurred at <b>6:55</b> A.M. from causes and on the date stated above			
22a SIGNATURE <b>Wilmer K. Gallagher</b>		22b DATE SIGNED <b>12/1/67</b>	
22c PHYSICIAN'S NAME (Type) <b>Dr. Wilmer K. Gallagher</b>		22d ADDRESS <b>6209 Frederick Ave., Catonsville, Md.</b>	
23a BURIAL, CREMATION, OR OTHER FINAL DISPOSITION (Specify) <b>BURIAL</b>		23b DATE THEREOF <b>12-2-1967</b>	
23c NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery</b>		23d LOCATION (City or Town) (County) (State) <b>Baltimore, Maryland</b>	
24 FUNERAL DIRECTOR <b>Howard H. Hubbard, 4107 Wilkens Avenue</b>		25a RECEIVED BY REGISTRAR <b>DEC 6 1967</b>	
ADDRESS <b>21229</b>		REGISTRAR'S SIGNATURE <b>James J. Judge</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Page 2 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 48 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
15032 BALTIMORE COUNTY CERTIFICATE OF DEATH 35											
1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>							
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u>				c. LENGTH OF STAY IN 1b <u>8 years</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE, MARYLAND</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>9508 AVONDALE ROAD, BALTO, MD.</u>				d. STREET ADDRESS <u>9508 AVONDALE ROAD.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>CLARENCE LEE MC CLASKEY</u>				4. DATE OF DEATH Month <u>NOV.</u> Day <u>29</u> Year <u>1967</u>							
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3-11-90.</u>		9. AGE (in years last birthday) <u>77</u> yrs.		IF UNDER 1 YEAR: Months <u>7</u> Days <u>7</u> Hours <u>7</u> Min. <u>7</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>WATCHMAN RAILROAD</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>RAILROAD.</u>				11. BIRTHPLACE (County & State, or foreign country) <u>961 WILFE ST. BALTO, MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>CHARLES EDWIN MC CLASKEY</u>				14. MOTHER'S MAIDEN NAME <u>ANNA GURLEY.</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. <u>705-10-9360</u>				17. INFORMANT <u>MRS. M. GRUMBACH</u>			
				Address <u>9508 AVONDALE RD.</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction, Acute.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arteriosclerotic heart disease.</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
INTERVAL BETWEEN ONSET AND DEATH <u>4-8 hours.</u>											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <u>None.</u>							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>None</u> p.m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>None</u>			
				20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <u>1964</u> , 19 <u>67</u> , to <u>11-29</u> , 19 <u>67</u> ; that (I) <u>was</u> last saw the deceased alive on <u>Nov. 16</u> , 19 <u>67</u> ; and that death occurred at <u>5:20 AM</u> from the causes and on the date stated above.											
22a. SIGNATURE <u>Ruben S. Sebastian</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED <u>11-29-67</u>			
22c. PHYSICIAN'S NAME (Type) <u>RUBEN S. SEBASTIAN</u>				22d. ADDRESS <u>2314 E. JORRA ROAD, BALTO., MD.</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>12/2/67.</u>				23c. NAME OF CEMETERY OR CREMATORY <u>Baltimore Cemetery</u>			
				23d. LOCATION (City, town or county) (State) <u>Baltimore, Md.</u>							
24. FUNERAL DIRECTOR <u>Leonard J. Ruck, Inc. Balto. Md. 21214</u>				25a. REC'D BY REGISTRAR <u>DEC-1 1967</u>				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			





# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

15033

15036

1 PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
c. LENGTH OF STAY IN 1b <b>21210</b>		d. STREET ADDRESS <b>221 Ridgemed Rd.</b>	
3 NAME OF DECEASED (Type or print) First Middle Last <b>Marie Regina McCORMACK</b>		4 DATE OF DEATH Month Day Year <b>November 27, 19 67</b>	
5 SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 17, 1891</b>
9 AGE (In years last birthday) <b>76</b> yrs		10. IF UNDER 27 Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Homemaker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11 BIRTHPLACE (County & State, or foreign country) <b>New Jersey</b>		12 CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13 FATHER'S NAME <b>Nicholas Toppin</b>		14. MOTHER'S MAIDEN NAME <b>Bridget ?</b>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16 SOCIAL SECURITY NO. <b>441-03-0330B</b>	
17. INFORMANT <b>Harry G. McCormack</b>		Address <b>Above</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial infarction</b> DUE TO <b>Generalized arteriosclerotic cardiovascular disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Chronic cholecystolithiasis with acute cholecystitis; Hiatal hernia.</b>			
19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <del>(A)</del> (this hospital) attended the deceased from <b>11/25/</b> , 19 <b>67</b> , to <b>11/27/</b> , 19 <b>67</b> that <del>(A)</del> (we) last saw the deceased alive on <b>11/27/</b> , 19 <b>67</b> , and that death occurred at <b>12</b> <b>PM</b> from causes and on the date stated above.			
22a. SIGNATURE <b>Arturo A. Pidlaon M.D.</b>		22b. DATE SIGNED <b>11/27/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Arturo A. Pidlaon, M.D.</b>		22d. ADDRESS <b>7620 York Rd., Towson, Md. 21204</b>	
23a BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b DATE THEREOF <b>11-30-67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Druid Ridge</b>	23d. LOCATION (City or Town) (County) (State) <b>Pikesville Balto. Md.</b>
24 FUNERAL DIRECTOR <b>H.W. Jenkins &amp; Sons Co., 4905 York Rd.</b>		25a REC'D BY REGISTRAR <b>NOV 28 1967</b>	
		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66



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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15034

15037

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore 12</b>		c. LENGTH OF STAY IN 1b <b>Baltimore 12</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Armocost Nursing Home</b>		d. STREET ADDRESS <b>1537 Burnwood Road</b>	
3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>L.</b> Last <b>McCourt</b>		4. DATE OF DEATH Month <b>November</b> Day <b>21</b> Year <b>1967</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9/23/1883</b>
9. AGE (In years lost birthday) <b>84</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired - Clerk</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Charles H. McCourt</b>		14. MOTHER'S MAIDEN NAME <b>Mary A. McCaul</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>216-01-5645A</b>	
17. INFORMANT <b>Mrs. Teresa Maygers</b>		Address <b>(Same)</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>cardiac hemorrhage</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <b>331A</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>Oct 23 1967</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (1) (this hospital) attended the deceased from <b>Oct 23, 1967</b> , to <b>Nov 20, 1967</b> , that (1) (we) last saw the deceased alive on <b>Nov 20, 1967</b> , and that death occurred at <b>4:30 P.M.</b> , from causes and on the date stated above			
22a. SIGNATURE <b>Dr. Francis X. Carnody</b>		22b. DATE SIGNED <b>Nov 22 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. Francis X. Carnody</b>		22d. ADDRESS <b>3201 N. Charles St.</b>	
23a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>11/25/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral</b>	23d. LOCATION (City or Town) (County) (State) <b>Baltimore Md.</b>
24. FUNERAL DIRECTOR <b>H.W. Jenkins &amp; Sons Co. 4905 York Road Baltimore, Md. 21212</b>		25a. REC'D BY REGISTRAR <b>NOV 27 1967</b>	
		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
15035  
1967  
12-601  
CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>		c. LENGTH OF STAY IN 1b <b>45 DAYS</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>VETERANS ADMINISTRATION HOSPITAL</b>		d. STREET ADDRESS <b>1606 VINCENT COURT,</b>	
3 NAME OF DECEASED (Type or print) First <b>JAMES</b> Middle <b>-</b> Last <b>MC CROREY</b>		4 DATE OF DEATH Month <b>NOVEMBER</b> Day <b>30</b> Year <b>19 67</b>	
5 SEX <b>MALE</b>	6. COLOR OR RACE <b>NEGRO</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>7/4/93</b>
9. AGE (In years last birthday) yrs. <b>74</b>		10. IF UNDER 1 YEAR Months Days Hours Min	11. IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>PORTER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>SEMINARY</b>	
11 BIRTHPLACE (County & State, or foreign country) <b>CHESTER, SOUTH CAROLINA</b>		12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>FRANK MC CROREY</b>		14 MOTHER'S MAIDEN NAME <b>MARY MN: UNKNOWN</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>YES WW I</b>		16. SOCIAL SECURITY NO. <b>217 12 91 38</b>	
17. INFORMANT <b>CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>BRONCHOPNEUMONIA</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>METASTATIC, ABDOMINAL CARCINOMA</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>DAYS</b> <b>UNKNOWN</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>ARTERIOSCLEROTIC HEART DISEASE</b>		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f (City or town) (County) (State)
21. I certify that (if this hospital) attended the deceased from <b>10/16/67</b> , 19__, to <b>11/30/67</b> , 19__, that (we) last saw the deceased alive on <b>11/30/67</b> , 19__, and that death occurred at <b>8:55 PM</b> , from causes and on the date stated above.			
22a SIGNATURE <i>John D. Talbert</i>		22b DATE SIGNED <b>12/1/67</b>	
22c PHYSICIAN'S NAME (Type) <b>JOHN D. TALBERT, M. D.</b>		22d ADDRESS <b>VAH FORT HOWARD, MARYLAND</b>	
23a BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b DATE THEREOF <b>12/5/67</b>	23c NAME OF CEMETERY OR CREMATORY <b>BALTIMORE NATIONAL</b>	23d LOCATION (City or town) (County) (State) <b>BALTIMORE, MARYLAND</b>
24. FUNERAL DIRECTOR <b>LAW FUNERAL HOME</b>		25a REC'D BY REGISTRAR <b>DEC 6 1967</b>	25b REGISTRAR'S SIGNATURE <i>Charles Judge</i>

802 N. Madison Ave. Baltimore, Md.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15036

15038

1 PLACE OF DEATH a COUNTY <b>BALTIMORE</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE <b>MARYLAND</b> b. COUNTY	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>		c LENGTH OF STAY IN 1b <b>118 DAYS</b>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>VETERANS ADMINISTRATION HOSPITAL</b>		d STREET ADDRESS <b>2307 Calverton Heights Avenue</b>	
3 NAME OF DECEASED (Type or print) First <b>EUGENE</b> Middle <b>-</b> Last <b>MC FADDEN</b>		4 DATE OF DEATH Month <b>NOVEMBER</b> Day <b>20</b> Year <b>19 67</b>	
5 SEX <b>MALE</b>	6. COLOR OR RACE <b>NEGRO</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12/25/23</b>
9 AGE (In years last birthday) <b>43</b> yrs.		10. AGE (In years last birthday) <b>43</b> yrs.	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>COOK</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>RESTAURANT</b>	
11 BIRTHPLACE (County & State, or foreign country) <b>BISHOPSVILLE, S. C.</b>		12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>RAYMOND MC FADDEN</b>		14. MOTHER'S MAIDEN NAME <b>CAROLYN DAVIS</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>YES PL 28</b>		16. SOCIAL SECURITY NO <b>219 01 41 51</b>	
17. INFORMANT <b>CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>BRONCHOPNEUMONIA</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>RECURRENT CARCINOMA, MOUTH AND NECK</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>RECENT</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE (CONDITION GIVEN IN PART I (a))		19 WAS ALTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour <b>a.m.</b> 19	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (if this hospital) attended the deceased from <b>7/25/67</b> 19 to <b>11/20/67</b> 19, that (we) last saw the deceased alive on <b>11/20/67</b> 19, and that death occurred <b>6:30 AM</b> on <b>11/20/67</b> 19, from causes and on the date stated above.			
22a. SIGNATURE <i>George C. McElpatrick, M.D.</i>		22b. DATE SIGNED <b>11/20/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>GEORGE C. MC ELPATRICK, M. D.</b>		22d. ADDRESS <b>VAH FORT HOWARD, MARYLAND</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>11-24-67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>BALTIMORE NATIONAL</b>	23d. LOCATION (City or Town) (County) (State) <b>BALTIMORE, MARYLAND</b>
24. FUNERAL DIRECTOR <b>MORTEN &amp; DYETTE FUNERAL HOME</b>		25a. REC'D BY REGISTRAR <b>NOV 21 1967</b>	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		25c. REGISTRAR'S NAME <b>CHARLES JUDGE</b>	

1701 LAURENS ST. BALTIMORE, MD.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

15037

15039

1 PLACE OF DEATH a COUNTY <b>Baltimore</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c LENGTH OF STAY IN 1b <b>Catonsville</b>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Ridgeway Manor Nursing Home</b>		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Albert McGonigle, Sr.</b>		4 DATE OF DEATH Month <b>November</b> Day <b>14</b> Year <b>67</b>	
5 SEX <b>Male</b>	6 COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 3, 1887</b>
9 AGE (in years last birthday) <b>80</b> yrs		10. IF UNDER 1 YEAR Months <b>80</b> Days <b>0</b> Hours <b>0</b> Min <b>0</b>	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Captain</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Balto. City Fire Dept.</b>	
11 BIRTHPLACE (County & State, or foreign country) <b>Baltimore, Maryland</b>		12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Peter J. McGonigle</b>		14. MOTHER'S MAIDEN NAME <b>Anna</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT <b>Mrs. Albert McGonigle, 215 Cherrydale Road</b>		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: <b>1824</b> IMMEDIATE CAUSE (a) <b>Heart Failure</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <b>1824</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>10 Oct</b> , 19 <b>67</b> , to <b>14 Nov</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>14 Nov</b> 19 <b>67</b> , and that death occurred at <b>3 PM</b> , from causes and on the date stated above.			
22a SIGNATURE <b>William Goodman</b>		22b DATE SIGNED <b>15 Nov 67</b>	
22c PHYSICIAN'S NAME (Type) <b>Dr. William Goodman</b>		22d ADDRESS <b>1334 Sulphur Spring Road, Balto., Md.</b>	
23a BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b DATE THEREOF <b>11-17-1967</b>	23c NAME OF CEMETERY OR CREMATORY <b>New Cathedral Cemetery</b>	23d LOCATION (City or Town) (County) (State) <b>Baltimore, Maryland</b>
24 FUNERAL DIRECTOR <b>Howard H. Hubbard, 4107 Wilkens Avenue 21229</b>		25a REC'D BY REGISTRAR DATE <b>NOV 17 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>William J. Judge</b>			



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If city delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15040

1 PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY			
b. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) <b>Baltimore</b>				c. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) <b>Baltimore</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>St. Joseph Hospital</b>				e. STREET ADDRESS <b>1000 Reveryd Rd.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <b>BARBARA : Ann McGuire</b>				4 DATE OF DEATH Month <b>November</b> Day <b>20</b> Year <b>1967</b>			
5 SEX <b>Female</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8-26-1955</b>		9 AGE (In years lost birthday) <b>12</b> yrs	10 IF UNDER 1 YEAR Months <b>12</b> Days <b>12</b> Hours <b>12</b> Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Student</b>		10b. KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (State or foreign country) <b>Balto., Md.</b>		12 CITIZEN OF WHAT COUNTRY? <b>USA</b>	
3 FATHER'S NAME <b>Francis J. McGuire</b>				14 MOTHER'S M.A.DEN NAME <b>Adelaide Horsey</b>			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16 SOC. A. SECURITY NO. <b>---</b>		17 INFORMANT <b>Francis J. McGuire</b>		Address <b>Above</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a) (b) (c) (d)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Interstitial myocarditis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) (c) (d) PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour <b>0</b> m <b>19</b> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)	
21 I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Edward F. Wilson</b> M.D.				22. DATE SIGNED <b>November 20, 1967</b>			
EXAMINER'S NAME (Type) <b>Edward F. Wilson, M.D.</b>				Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11-22-67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Gardens of Faith</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore Md.</b>	
24 FUNERAL DIRECTOR <b>H.W. Jenkins &amp; Sons Co.</b>				25a. REC'D BY REGISTRAR <b>NOV 21 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Francis Judge</b>	



**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**

15039

**CERTIFICATE OF DEATH**

15041

<b>1 PLACE OF DEATH</b> a. COUNTY <b>BALTIMORE</b> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>TOWSON</b> c. LENGTH OF STAY IN IS <i>days</i> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>ST. JOSEPH HOSPITAL</b>			<b>2 USUAL RESIDENCE</b> (Where deceased lived, if institution Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>TOWSON</b> d. STREET ADDRESS <b>609 VALLEY LANE #21204</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <b>GEORGE W. McLAREN, M.D.</b> D.D.S.			<b>4 DATE OF DEATH</b> Month Day Year <b>NOVEMBER 13 19 67</b>		
<b>5 SEX</b> <b>MALE</b>	<b>6 COLOR OR RACE</b> <b>WHITE</b>	<b>7 MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8 DATE OF BIRTH</b> <b>AUGUST 29, 1896</b>	<b>9 AGE</b> (In years last birthday) <b>71</b> YES <input type="checkbox"/> NO <input type="checkbox"/>	<b>IF UNDER 1 YEAR</b> Months Days <b>IF UNDER 24 HRS</b> Hours Min
<b>10a USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>PHYSICIAN Dentist</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>	<b>11 BIRTHPLACE</b> (County & State, or foreign country) <b>PITTSBURGH, PENNA.</b>		<b>12 CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>
<b>13 FATHER'S NAME</b> <b>Malcolm G. McLaren 111</b>			<b>14. MOTHER'S MAIDEN NAME</b> <b>Carrie Shorb</b>		
<b>15 WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		<b>16 SOCIAL SECURITY NO</b> <b>172-12-2605A</b>	<b>17 INFORMANT</b> Address <b>Mrs. Evelyn McLaren, Same as # 2</b>		
<b>18 CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b> DUE TO (b) <b>MASSIVE MYOCARDIAL INFARCTION</b> DUE TO (c) <b>ARTERIOSCLEROTIC HEART DISEASE</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost					<b>INTERVA. BETWEEN ONSET AND DEATH</b>
<b>PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)</b>					<b>19 WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
<b>20a ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTR. BUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b DESCRIBE HOW INJURY OCCURRED</b> (Enter nature of injury in Part I or Part II of item 18)			
<b>20c TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <b>19</b>	<b>20d INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	<b>20e PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)	<b>20f (City or town)</b> (County) (State)		
<b>21 I certify that (I) (this hospital) attended the deceased from <u>NOVEMBER 9, 1967</u>, to <u>NOVEMBER 13, 1967</u> that (I) (we) last saw the deceased alive on <u>NOVEMBER 13, 19 67</u>, and that death occurred at <u>12:05 AM</u> from causes and on the date stated above</b>					
<b>22a SIGNATURE</b> <i>Jaime Singzon</i>			<b>22b DATE SIGNED</b> <b>NOVEMBER 13, 1967</b>		
<b>22c PHYSICIAN'S NAME</b> (Type) <b>JAIME SINGZON, M. D.</b>			<b>22d ADDRESS</b> <b>7620 YORK ROAD TOWSON, MD. #21204</b>		
<b>23a BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>	<b>23b DATE THEREOF</b> <b>Nov. 15, 1967</b>	<b>23c NAME OF CEMETERY OR CREMATORY</b> <b>Dulaney Valley Cemetery</b>	<b>23d LOCATION</b> (City or Town) (County) (State) <b>Cockeysville, Md.</b>		
<b>24 FUNERAL DIRECTOR</b> ADDRESS <b>Wm. Cook-Brooks Towson, 1050 York Road Towson, Md. 21204</b>			<b>25a REC'D BY REGISTRAR</b> <b>NOV 15 1967</b>	<b>25b REGISTRAR'S SIGNATURE</b> <i>Charles Judge</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-5. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

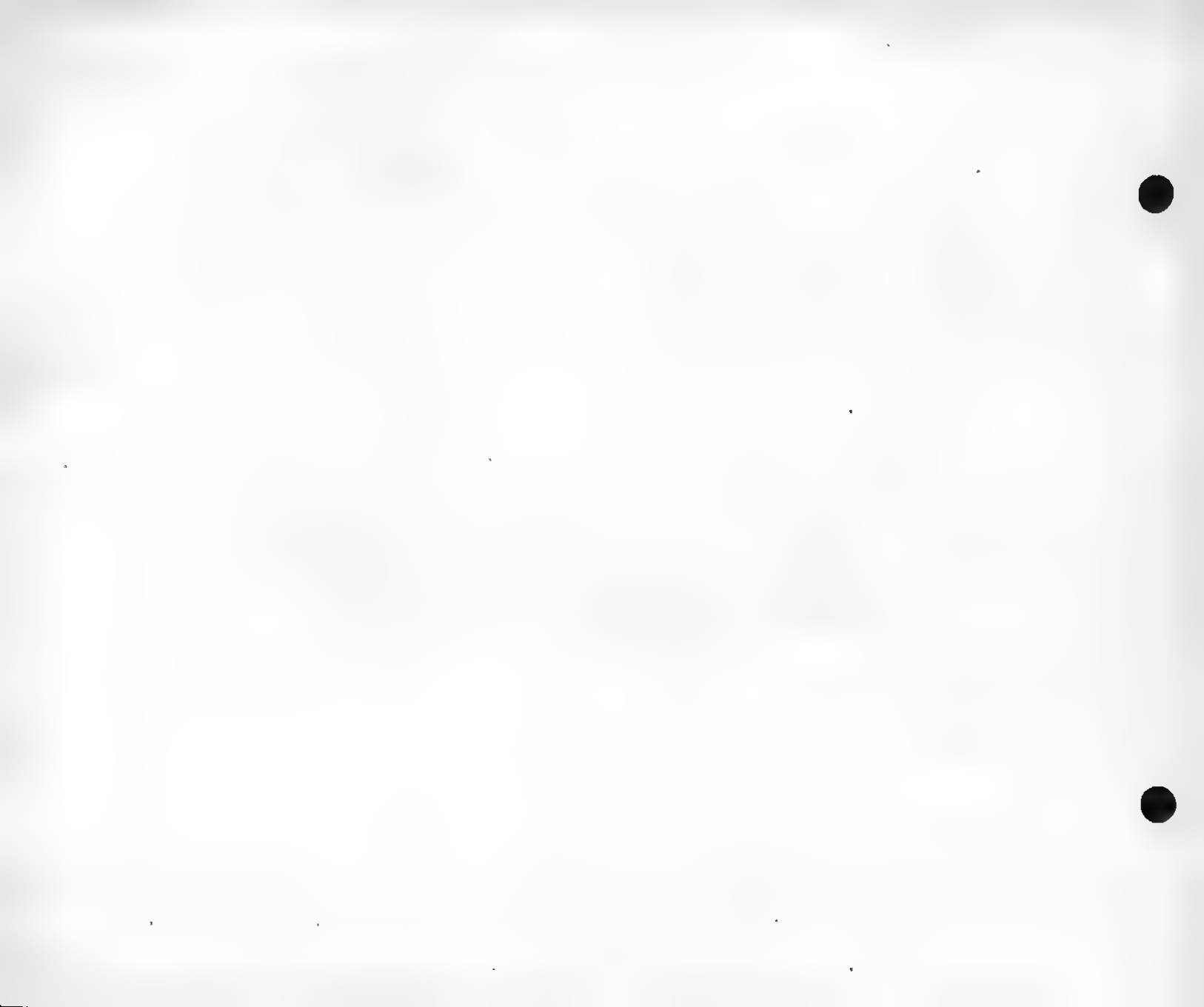
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15040

15042

1 PLACE OF DEATH a COUNTY <b>BALTIMORE</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) a STATE <b>MARYLAND</b> b COUNTY <b>BALTO</b>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Balto Rural Parkville</b>		c LENGTH OF STAY IN 1b <b>Balto Rural 24 Parkville</b>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>2914 Hillcrest Balto 34</b>		d STREET ADDRESS <b>2914 Hillcrest</b>	
3 NAME OF DECEASED (Type or print) <b>MATJE Mae McPHERSON</b>		4 DATE OF DEATH <b>November 21 19 67</b>	
5. SEX <b>Female</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>28 July 1895</b>
9 AGE (In years last birthday) <b>72</b> yrs		F UNDER 1 YEAR Months Days	IF UNDER 24 HRS Hours Min
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (State or foreign country) <b>Maryland</b>		12 CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13 FATHER'S NAME <b>David C. Hood</b>		14 MOTHER'S MAIDEN NAME <b>Matilda Kaltenbach</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16 SOC. SEC. SECURITY NO.	
17 INFORMANT <b>Mrs Mamie Hood Severna Park, Md.</b>		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Atherosclerotic Cardiovascular</b> DUE TO <b>Deamie</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			INTERVAL BETWEEN ONSET AND DEATH <b>undet.</b>
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc)	20f (City or town) (County) (State)
21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>John C. Hyle</b> M.D. EXAMINER'S NAME (Type) <b>JOHN C. Hyle</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street city town or county) <b>7577 Belair Rd 36</b>	
23a BURIAL CREMATION, or MOVAL (Specify) <b>burial</b>	23b DATE THEREOF <b>11-24-67</b>	23c NAME OF CEMETERY OR CREMATORY <b>Baltimore Nat'l</b>	23d LOCATION (City or town) (County) (State) <b>Baltimore, Md.</b>
24 FUNERAL DIRECTOR <b>Leonard J. Ruck, Inc Baltimore, Md.</b>		25a REC'D BY REGISTRAR DATE NOV 22 1967	25b REGISTRAR'S SIGNATURE <b>Charles Judge</b>





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

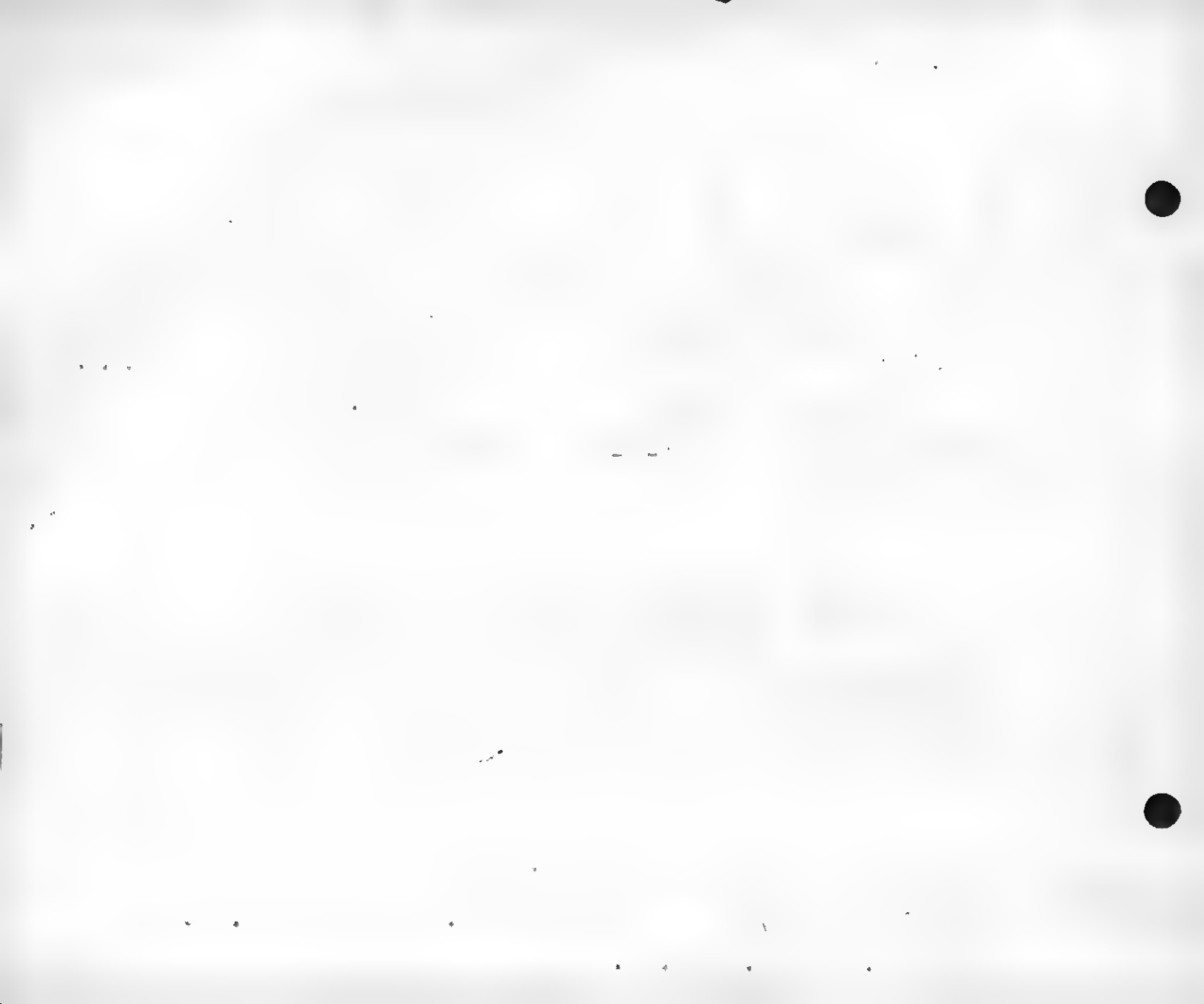
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

# CERTIFICATE OF DEATH

15044

15043

1 PLACE OF DEATH a COUNTY <b>Baltimore</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE <b>Maryland</b> b COUNTY	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson, 21204</b>		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore - 21234</b>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>St. Joseph Hospital</b>		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First <b>JAMES</b> Middle <b>HENRY</b> Last <b>McWILLIAMS</b>		4 DATE OF DEATH Month <b>November</b> Day <b>21</b> Year <b>19 67</b>	
5 SEX <b>Male</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>May 23, 1899</b>
9 AGE (In years last birthday) <b>68</b> yrs		10 IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Machinist</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13 FATHER'S NAME <b>John Andrew McWilliams</b>		14 MOTHER'S MAIDEN NAME <b>Annie V. Wholey</b>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16 SOCIAL SECURITY NO <b>212-09-8735</b>	
17 INFORMANT <b>Gertrude McWilliams</b>		Address <b>same</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>Carcinomatosis --</b> DUE TO <b>Primary in either Liver, Pancreas or Kidney</b> (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c TIME OF INJURY Month Day, Year Hour a.m. p.m. <b>19</b>	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (1) (this hospital) attended the deceased from <b>Nov. 3, 1967</b> , to <b>Nov. 21, 1967</b> , that (1) (we) last saw the deceased alive on <b>Nov. 21, 19 67</b> , and that death occurred at <b>4:45 PM</b> , from causes and on the date stated above.			
22a SIGNATURE <i>Jaime Singzon</i>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>Jaime Singzon, M.D.</b>		22d. ADDRESS <b>7620 York Rd., Towson, Md. 21204</b>	
23a BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b DATE THEREOF <b>11/25/67</b>	23c NAME OF CEMETERY OR CREMATORY <b>New Cathedral Cem.</b>	23d. LOCATION (City or Town) (County) (State) <b>Balto. Md.</b>
24. FUNERAL DIRECTOR <b>Leonard J. Ruck Inc. Balto. Md.</b>		25a. REC'D BY REGISTRAR <b>NOV 24 1967</b>	
ADDRESS		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

15045

1. NAME OF DECEASED  
Type or Print

Luther Moritz Ernest Menkel

2. DATE AND HOUR OF DEATH

11-15-1967

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF  
HOSPITAL OR  
INSTITUTION

(If not in hospital, or institution, give street  
address or location)

4519 Forrestview Avenue

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Md.

C. CITY OR TOWN

(If outside city limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS

(If rural, give location)

4519 Forrestview Avenue 21206

5. SEX

Male

6. RACE

Cau

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (Specify)  
Married

8. DATE OF BIRTH

11-8-1902

9. AGE (In years  
lost birthday)

65

If Under 1 Yr.  
Months Days

If Under 24 Hrs.  
Hours Min.

10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Ret. Clergyman

10B. KIND OF BUSINESS OR INDUSTRY

Lutheran Church

11. BIRTHPLACE (State or foreign country)

Baltimore, Maryland

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Frederick Menkel

14. MOTHER'S MAIDEN NAME

Anna B. Ernst

15. Was Deceased Ever in U. S. Armed Forces?

No

(If yes, give war or dates of service)

16. SOCIAL  
SECURITY NO.

213-36-8928

17. INFORMANT

Mrs. Rosalie B. Menkel 4519 Forrestview Ave.

ADDRESS

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

(A) DUE TO

(B) DUE TO

(C) DUE TO

19. ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.

Acute Myocardial Infarction Sudden  
Arteriosclerotic Cardiovascular disease 10 yrs

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT

22. I certify that (I) (this hospital) attended the deceased from Nov 15 1967 to Nov 16 1967  
that (I) (we) last saw the deceased alive on Nov 15 1967 and that in (my) (our) opinion death occurred on the date  
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

M.D.

Attending  
Phys.

Med.  
Director

Staff  
Phys.

23B. DATE SIGNED

11-17-67

23C. PHYSICIAN'S  
NAME (Type)

G.M. Baumgardner

M.D.

23D. ADDRESS

Balts 21237

Md

24A. BURIAL CREMATION, 24B. DATE  
REMOVAL (Specify)

Burial

11-16-1967

24C. NAME OF CEMETERY or CREMATORY

Louisa Park Cemetery

24D. LOCATION

Baltimore,

(City, town, or county)

(State)

VR A15 (4)  
25M 1/67

25A. DATE REC'D BY HEALTH DEPT.

NOV 21 1967

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

Massachusetts Funeral Home 7401 Balan Rd

ADDRESS

36

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health department within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15043

CERTIFICATE OF DEATH

15046

1. PLACE OF DEATH a. COUNTY <u>BALTO</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>BALTO</u>			
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>ROSEDALE</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ROSEDALE</u>		03.1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>8208 ANALEE</u>				d. STREET ADDRESS <u>8208 ANALEE</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>FRANCES ALICE MEYER</u>				4. DATE OF DEATH Month Day Year <u>NOV. 30 1967</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/28/29</u>		9. AGE (In years last birthday) <u>38</u> yrs	10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State or foreign country) <u>BALTO, MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>VERNON KELLER</u>				14. MOTHER'S MAIDEN NAME <u>HELEN HRVZ</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO <u>213-26-6198</u>		17. INFORMANT <u>WM. J. MEYERS</u>		Address <u>ABOVE</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: <u>TOX</u> IMMEDIATE CAUSE (a) <u>Pulmonary Metastases</u> DUE TO (b) <u>Carcinoma, Breast</u> DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>June</u> , 19 <u>67</u> , to <u>12/30</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>12/30</u> , 19 <u>67</u> , and that death occurred at <u>11:30</u> AM, from causes and on the date stated above							
22a. SIGNATURE <u>John G. Orth, MD</u>				ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED <u>12/31/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>John G. Orth, MD</u>				22d. ADDRESS <u>8019 Philadelphia Rd</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>12/4/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>SACRED HEART</u>		23d. LOCATION (City or Town) (County) (State) <u>BALTO. MD.</u>	
24. FUNERAL DIRECTOR <u>J.G. CONNELLY SONS</u>				25a. REC'D BY REGISTRAR <u>300 MACE</u>		25b. REGISTRAR'S SIGNATURE <u>John Charles Judge</u>	



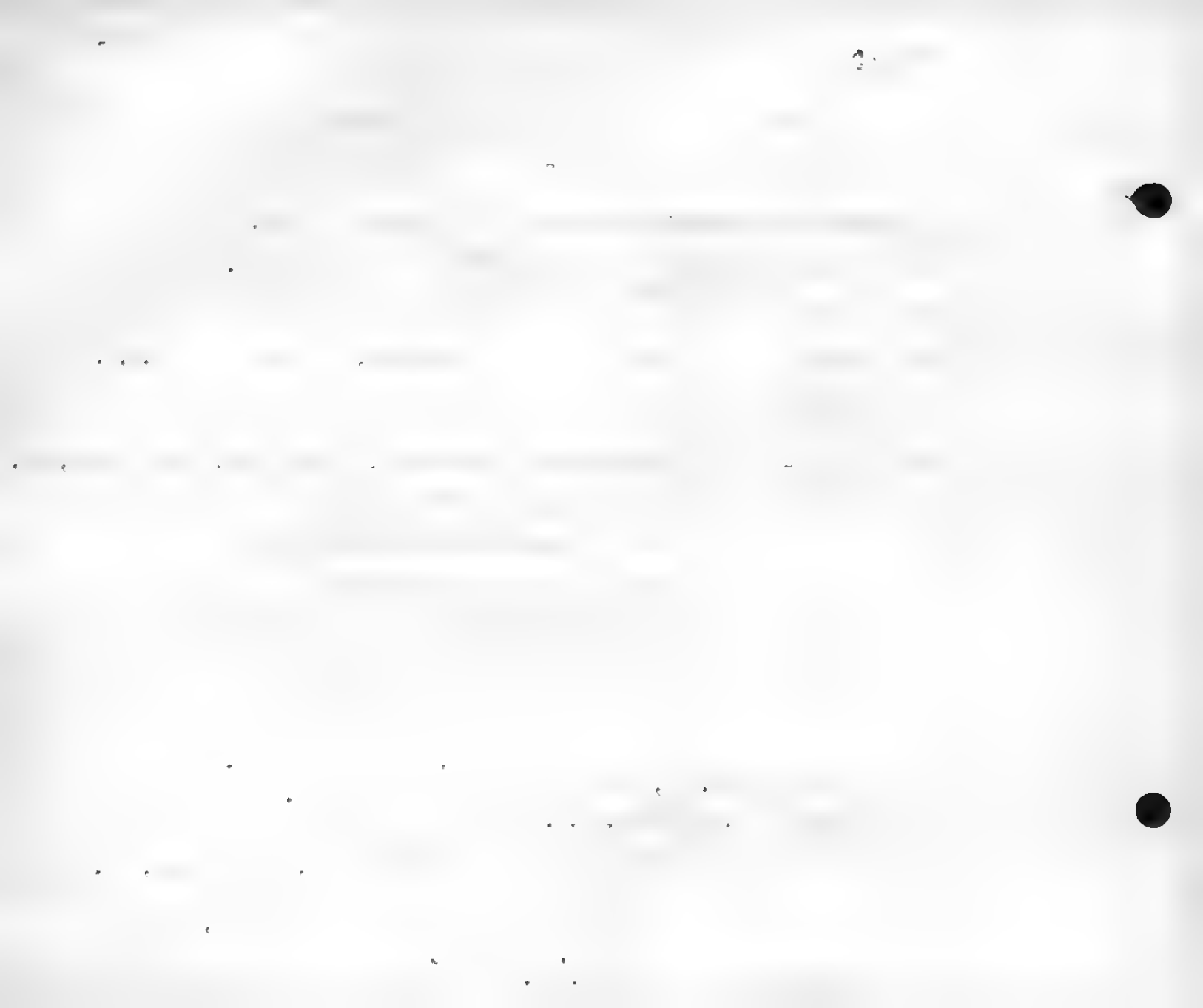
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15044

CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>		c. LENGTH OF STAY IN 1b <b>14 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Veterans Administration Hospital</b>		d. STREET ADDRESS <b>1823 Druid Hill Ave.</b>	
3 NAME OF DECEASED (Type or print) <b>HORACE ERNEST MILBURN</b>		4 DATE OF DEATH <b>Nov. 10 1967</b>	
5 SEX <b>Male</b>	6 COLOR OR RACE <b>Negro</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>8/12/07</b>
9 AGE (In years last birthday) yrs. <b>60</b>		IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) <b>Truck Helper</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Brewery</b>	
11 BIRTHPLACE (County & State or foreign country) <b>Baltimore, Maryland</b>		12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13 FATHER'S NAME <b>Roy Milburn</b>		14. MOTHER'S MAIDEN NAME <b>Carrie Bell</b>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes HW-11</b>		16 SOCIAL SECURITY NO <b>214 18 23 23</b>	
17. INFORMANT <b>Clinical Rcds, VA Hospital, Fort Howard, Md.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>MYOCARDIAL INFARCTION</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <b>HEPATIC FAILURE, LARNECS CIRRHOSIS</b> (c) <b>SEPTICIMIA, DUE TO ALCOHOLISM</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Hours</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOT BY MED. CA. EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part I of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f. (City or town) (County) (State)
21 I certify that (this hospital) attended the deceased from <b>Oct. 27</b> , 19 <b>67</b> to <b>Nov. 10</b> , 19 <b>67</b> that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>Nov. 10</b> , 1967, and that death occurred at <b>8:59a</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>GRACITO V. PATIRCIQ, M.D.</b> M.D.		22b. DATE SIGNED <b>11/10/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Gracito V. Patircio</b>		22d. ADDRESS <b>VA Hospital, Fort Howard, Md.</b>	
23a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>11/14/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>	23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Maryland</b>
24. FUNERAL DIRECTOR <b>NUTTER FUNERAL HOME</b>		25a. REC'D BY REGISTRAR <b>NOV 13 1967</b>	25b. REGISTRAR'S SIGNATURE <i>William Judge</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

Item 18 part 11 film 39 MARYLAND STATE DEPARTMENT OF HEALTH  
11-30-67 mt DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15045

CERTIFICATE OF DEATH

15048

1 PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>		c. LENGTH OF STAY IN 1b <b>107 DAYS</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>VETERANS ADMINISTRATION HOSPITAL</b>		e. STREET ADDRESS <b>210 OTTERBEIN STREET</b>	
3 NAME OF DECEASED (Type or print) First <b>EDWARD</b> Middle <b>--</b> Last <b>MILLER</b>		4 DATE OF DEATH Month <b>NOVEMBER</b> Day <b>19</b> Year <b>1967</b>	
5 SEX <b>MALE</b>	6 COLOR OR RACE <b>NEGRO</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>3/10/96</b>
9 AGE (In years last birthday) <b>71</b> yrs		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>WAREHOUSE MAN</b>	
10b. KIND OF BUSINESS OR INDUSTRY <b>BUILDING SUPPLY CO.</b>		11 BIRTHPLACE (County & State or foreign country) <b>ELIZABETH CITY, N.C.</b>	
12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13 FATHER'S NAME <b>BENJAMIN MILLER</b>	
14 MOTHER'S MAIDEN NAME <b>MARY E. JAMES</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>YES WW-1</b>	
16. SOCIAL SECURITY NO <b>217 07 8331</b>		17. INFORMANT <b>CLIN. REC., VAH, FT. HOWARD, MD.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>POST OPERATIVE HEMORRHAGE, OPERATIVE SITE</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <b>BRONCHOPNEUMONIA</b> (c) <b>PULMONARY CONGESTION AND EDEMA</b>		INTERVAL BETWEEN ONSET AND DEATH <b>RECENT</b> <b>RECENT</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>SURGICAL ABSENCE RIGHT LOWER EXTREMITY, RECENT, Arteriosclerosis of c</b>		19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <b>Gangrene</b>	
20c TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that (1) (this hospital) attended the deceased from <b>8/4/67</b> , 19 to <b>11/19/67</b> , 19, that (2) (we) last saw the deceased alive on <b>11/19/67</b> , 19, and that death occurred at <b>9:35A</b> M, from causes and on the date stated above.			
22a SIGNATURE <i>George C. McElpatrick</i>		22b DATE SIGNED <b>11/21/67</b>	
22c PHYSICIAN'S NAME (Type) <b>GEORGE C. McELPATRICK, M. D.</b>		22d ADDRESS <b>VAH FORT HOWARD, MARYLAND</b>	
23a BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b DATE THEREOF <b>11/24/67</b>	23c NAME OF CEMETERY OR CREMATORY <b>BALTIMORE NATIONAL</b>	23d LOCATION (City or Town) (County) (State) <b>BALTIMORE, MARYLAND</b>
24 FUNERAL DIRECTOR <i>Charles A. Rice</i>		25a REC'D BY REGISTRAR <b>W. BARRE STREET, BALTIMORE, MD.</b>	
25b REGISTRAR'S SIGNATURE <i>Charles A. Rice</i>		25c REGISTRAR'S SIGNATURE <i>Charles A. Rice</i>	

VR A15 (4)  
25M 1/67

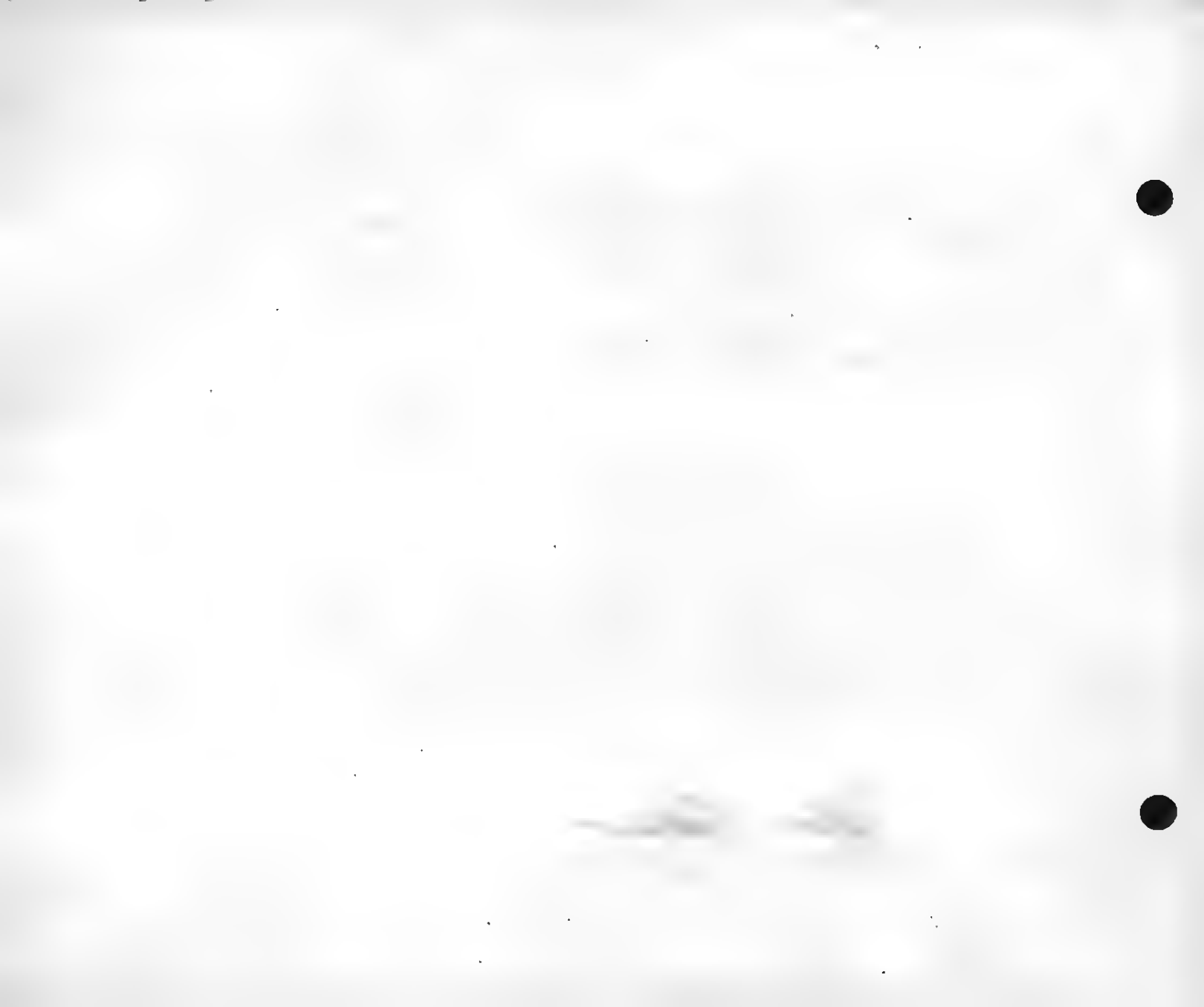


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VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY Baltimore						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Towson						c. LENGTH OF STAY IN 1b 26 days					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) GREATER BALTIMORE MEDICAL CENTER						e. STREET ADDRESS 8 MARYLAND AVE					
3. NAME OF DECEASED (Type or print) First JANE Middle H Last MILLER						4. DATE OF DEATH Month 11 Day 1 Year 1967					
5. SEX Female		6. COLOR OR RACE Cauc.		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6/6/1894		9. AGE (In years last birthday) 73 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. State of Md.				10b. KIND OF BUSINESS OR INDUSTRY J.M.V.		11. BIRTHPLACE (County & State, or foreign country) MARYLAND (Balto)				12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME LAURENCE MILLER						14. MOTHER'S MAIDEN NAME CHARIE Colton					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. 225-18-1793		17. INFORMANT PATIENT'S CHART					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis 165X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of lung DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 10/7, 1967, to 11/1, 1967, that (I) (we) last saw the deceased alive on 11/1, 1967, and that death occurred at 11:55 p.m. from the causes and on the date stated above.											
22a. SIGNATURE John E. Adams						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 11/2/67	
22c. PHYSICIAN'S NAME (Type) John E. Adams, M. D.						22d. ADDRESS Greater Baltimore Medical Center					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF 11-4-67		23c. NAME OF CEMETERY OR CREMATORY St Anne's				23d. LOCATION (City, town or county) (State) Annapolis Md			
24. FUNERAL DIRECTOR John M. Lyster Sons Company, Inc.						25a. REC'D BY REGISTRAR NOV 6 1967		25b. REGISTRAR'S SIGNATURE Charles Judge			

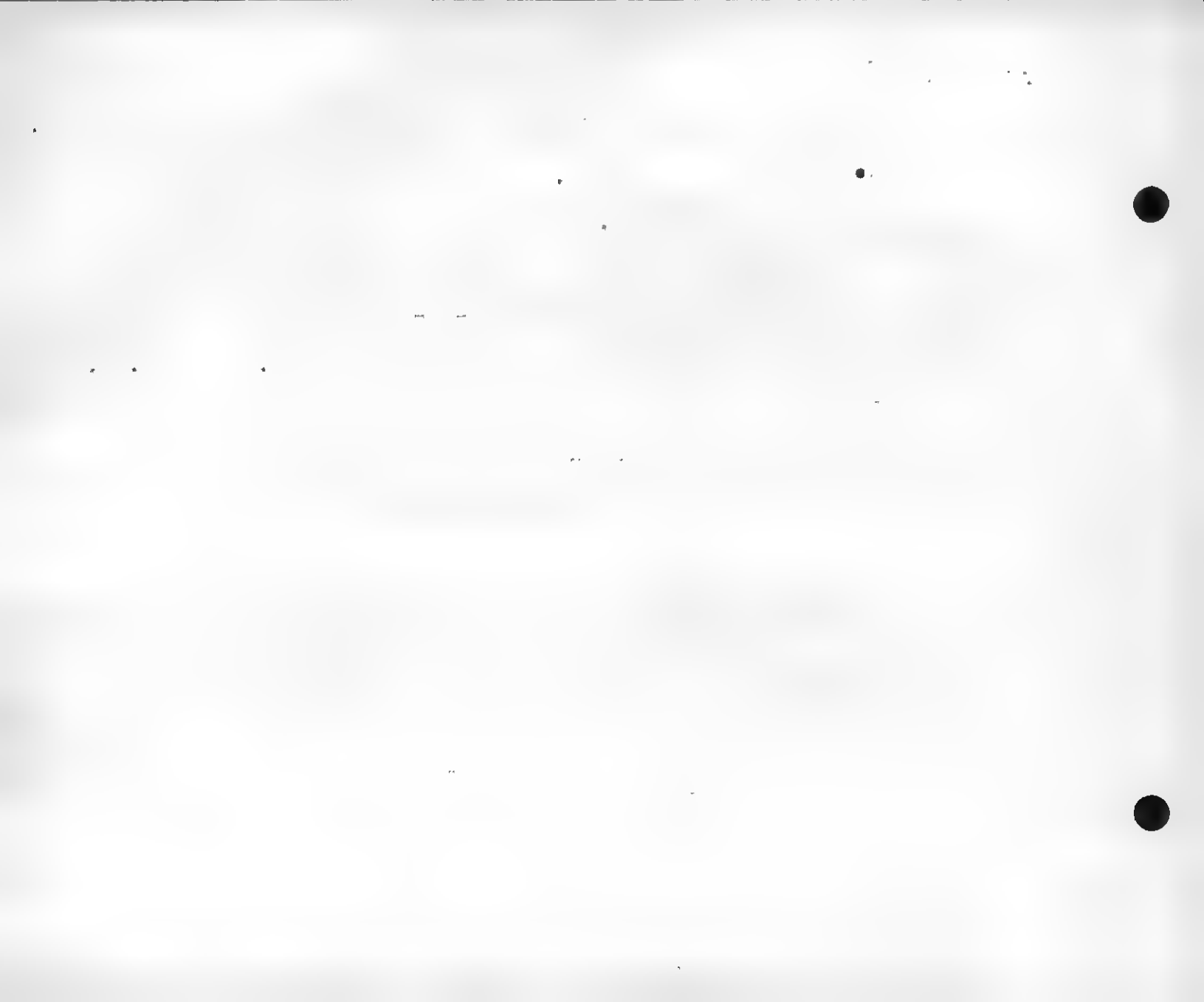


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH			
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201			
CERTIFICATE OF DEATH			
1 PLACE OF DEATH a. COUNTY <b>Baltimore</b>		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Geo.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Beltsville</b>	
c. LENGTH OF STAY IN 1b <b>6 wks.</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Spring Grove State Hosp.</b>		d. STREET ADDRESS <b>4505 Blackpool Drive</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First <b>James</b> Middle <b>I</b> Last <b>Moore</b>		4 DATE OF DEATH Month <b>11</b> Day <b>4</b> Year <b>1967</b>	
5 SEX <b>M</b>	6 COLOR OR RACE <b>W</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>7-29-85</b>
9 AGE (In years last birthday) yrs. <b>82</b>		IF UNDER 1 YEAR Months <b>4</b> Days <b>19</b> Hours <b>67</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unknown</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>Pittsburgh Pa.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Milton</b>		14. MOTHER'S MAIDEN NAME <b>Ida (UNKNOWN)</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Unknown</b>		16. SOCIAL SECURITY NO <b>210-03-5473</b>	
17. INFORMANT <b>Chart</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarction</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>ASCVD</b> DUE TO (c)			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>11-3</b> , 19 <b>67</b> , to <b>11-4</b> , 19 <b>67</b> that (I) (we) last saw the deceased alive on <b>11-4</b> , 19 <b>67</b> and that death occurred at <b>2:35 P.M.</b> from causes on and on the date stated above			
22a. SIGNATURE <b>[Signature]</b>		22b. DATE SIGNED <b>11-4-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Oscar G. PRADO, M.D.</b>		22d. ADDRESS <b>3315 Guilford Ave. Balto, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>11/7/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>CAK HILL</b>	23d. LOCATION (City or Town) (County) (State) <b>CLEARFIELD CO. PA.</b>
24. FUNERAL DIRECTOR <b>[Signature]</b>		25a. REC'D BY REG STRAR <b>NOV 7 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers pages 1 and 2, and in any event, within 72 hours after death, should be filed with the State Dept. of Health prior to burial, cremation, or removal.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15049

15051

1. PLACE OF DEATH a. COUNTY <u>Baltimore County</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>		c. LENGTH OF STAY IN 1b <u>3</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Dep't. of Health &amp; Women's Homes</u>		d. STREET ADDRESS <u>St. Paul St &amp; 3rd St.</u>	
3. NAME OF DECEASED (Type or print) First <u>Maria</u> Middle <u>Goodrich</u> Last <u>Moxley</u>		4. DATE OF DEATH Month <u>November</u> Day <u>11</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1878</u>
9. AGE (In years lost birthday) <u>89</u> yrs		10. IF UNDER 1 YEAR Months <u>5</u> Days <u>7</u> Hours <u>2</u> Min <u>30</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	
11. BIRTHPLACE (County & State or foreign country) <u>Kirkland, Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James Watson Moxley</u>		14. MOTHER'S MAIDEN NAME <u>Mary Valentine</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>Francis E. Stuckfus</u>	
17. INFORMANT <u>Francis E. Stuckfus</u>		Address <u>615 Chestnut St.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ASCVD</u> DUE TO (b) <u>Central Vascular Accident</u> DUE TO (c) <u>1 week</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>2/6</u> , 19 <u>69</u> to <u>Nov 11</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>Nov 11</u> , 19 <u>67</u> , and that death occurred at <u>2:30</u> P.M. from causes and on the date stated above			
22a. SIGNATURE <u>Newland Edward Day</u>		22b. DATE SIGNED <u>November 11, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>Newland Edward Day</u>		22d. ADDRESS <u>Pickersgill</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>	23b. DATE THEREOF <u>11, 13, 67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Greenmount</u>	23d. LOCATION (City or town) (County) (State) <u>Baltimore, Md.</u>
24. FUNERAL DIRECTOR <u>Wm. Cook-Brooks Towson, Towson, Md.</u>		25a. REC'D BY REGISTRAR <u>NOV 15 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	





15049

## CERTIFICATE OF DEATH

15052

1 PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Balto.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
c. LENGTH OF STAY in lb <b>25 Yrs</b>		<b>1427 Providence Road</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>1427 Providence Rd. Balto. Md. 21204</b>		d. STREET ADDRESS <b>Balto. Md. 21204</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3 NAME OF DECEASED (Type or print) <b>John Moser Jr.</b>		4 DATE OF DEATH Month <b>11</b> Day <b>19</b> Year <b>67</b>	
5 SEX <b>Male</b>	6 COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>10-14-84</b>
9. AGE (In years last birthday) <b>83</b>		IF UNDER 1 YEAR Months <b>03</b> Days <b>19</b> Hours <b>19</b> Min <b>19</b>	
10a. USUAL OCCUPATION (Give kind of work done during last 12 months, or if retired)		10b. KIND OF BUSINESS OR INDUSTRY <b>Drug Store</b>	
11 BIRTHPLACE (County & State, or foreign country) <b>West Virginia</b>		12 CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John Moser</b>		14. MOTHER'S MAIDEN NAME <b>Arlene VanCamp</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO <b>214 26 8475</b>	
17. INFORMANT <b>Clarence A. Moser 1679 Thetford Rd.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. <b>4510 Acute Cardiac Failure</b> IMMEDIATE CAUSE (a) <b>Arteriosclerosis</b> DUE TO (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>21204</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Jan 10, 1964</b> to <b>Nov 19, 1967</b> , that (I) (we) last saw the deceased alive on <b>Nov 19, 1967</b> , and that death occurred at <b>11</b> M, from causes on and on the date stated above.			
22a. SIGNATURE <b>Laurence C. Post</b>		22b. DATE SIGNED <b>10/20/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Laurence C. Post</b>		22d. ADDRESS <b>6805 York Road. Balto. Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11-22-67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Parkwood</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Maryland</b>	
24. FUNERAL DIRECTOR <b>Wm. E. Johnson, 8521 Loch Raven Blvd. 21204</b>		25a. REC'D BY REGISTRAR <b>NOV 24 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>John E. Johnson</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper tags 1 through 4 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 12 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1-65

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

15050

15053

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>			c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Towson</u>		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>1002 N. Rolling Rd</u>			d. STREET ADDRESS <u>705 Fairway Drive</u>		
3. NAME OF DECEASED (Type or print) First Middle Last <u>Theresa Marie Mules</u>			4. DATE OF DEATH Month Day Year <u>11 27 1967</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 4 1877</u>		9. AGE (in years last birthday) <u>90</u> yrs. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>George Ernstberger</u>			14. MOTHER'S MAIDEN NAME <u>Catherine</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>220 48 3601</u>		17. INFORMANT Address <u>Mrs Beatrice K Nelson 705 Fairway Dr 21204</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY OCCASION</u> DUE TO (b) <u>ATHEROSCL. CVA/D</u> DUE TO (c) <u>-</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					INTERVAL BETWEEN ONSET AND DEATH <u>2 MIN.</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>1-21</u> , 19 <u>66</u> , to <u>11-27</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>11-21-67</u> 19 <u>67</u> , and that death occurred at <u>8 P</u> M, from the causes and on the date stated above.					
22a. SIGNATURE <u>John F. Schaefer</u>			22b. DATE SIGNED <u>11-29-67</u>		
22c. PHYSICIAN'S NAME (Type) <u>JOHN F. SCHAEFER MD</u>			22d. ADDRESS <u>401 RANDOM RD - BAH TO 21229 MD.</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>11-30-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cem</u>	23d. LOCATION (City, town or county) (State) <u>Balto Md</u>		
24. FUNERAL DIRECTOR ADDRESS <u>Burgee Funeral Home 3631 Falls Rd</u>			25a. REC'D BY REGISTRAR <u>DEC 1 1967</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

By Norval H. Bunge Jr



## CERTIFICATE OF DEATH

15054

15051

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>1</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
c. LENGTH OF STAY IN 1b <u>14 Yrs</u>		d. STREET ADDRESS <u>3607 Telmar Rd</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>3607 Telmar Rd</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>A.</u> Last <u>MURRAY</u>		4. DATE OF DEATH Month <u>November</u> Day <u>3</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-10-1883</u> 9. AGE (In years last birthday) <u>84</u> yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State or foreign country) <u>Bryantown, Charles Co</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James A. Murray, Sr.</u>		14. MOTHER'S MAIDEN NAME <u>Tolia Carrico</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) <u>No</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO <u>219-10-5667</u>	
17. INFORMANT <u>MARIE T. MURRAY - SANE</u> Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO (b) <u>Hypertension</u> DUE TO (c) <u>Spurred Aneurysm</u>			INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> m. <u>p.m.</u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>June</u> , 19 <u>67</u> to <u>Nov 3</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>Nov 23</u> , 19 <u>67</u> , and that death occurred at <u>11:00</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Dr. Thos G. Abbott</u> M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>Thos G. Abbott</u>		22d. ADDRESS <u>4509 Liberty Heights Ave</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>11-7-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cemetery</u>	23d. LOCATION (City or town) (County) (State) <u>Baltimore, Md.</u>
24. FUNERAL DIRECTOR <u>Elkworth Armacost</u> ADDRESS <u>9600 Liberty Heights Ave</u>		25a. RECD BY REGISTRAR <u>NOV 6 1967</u> 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

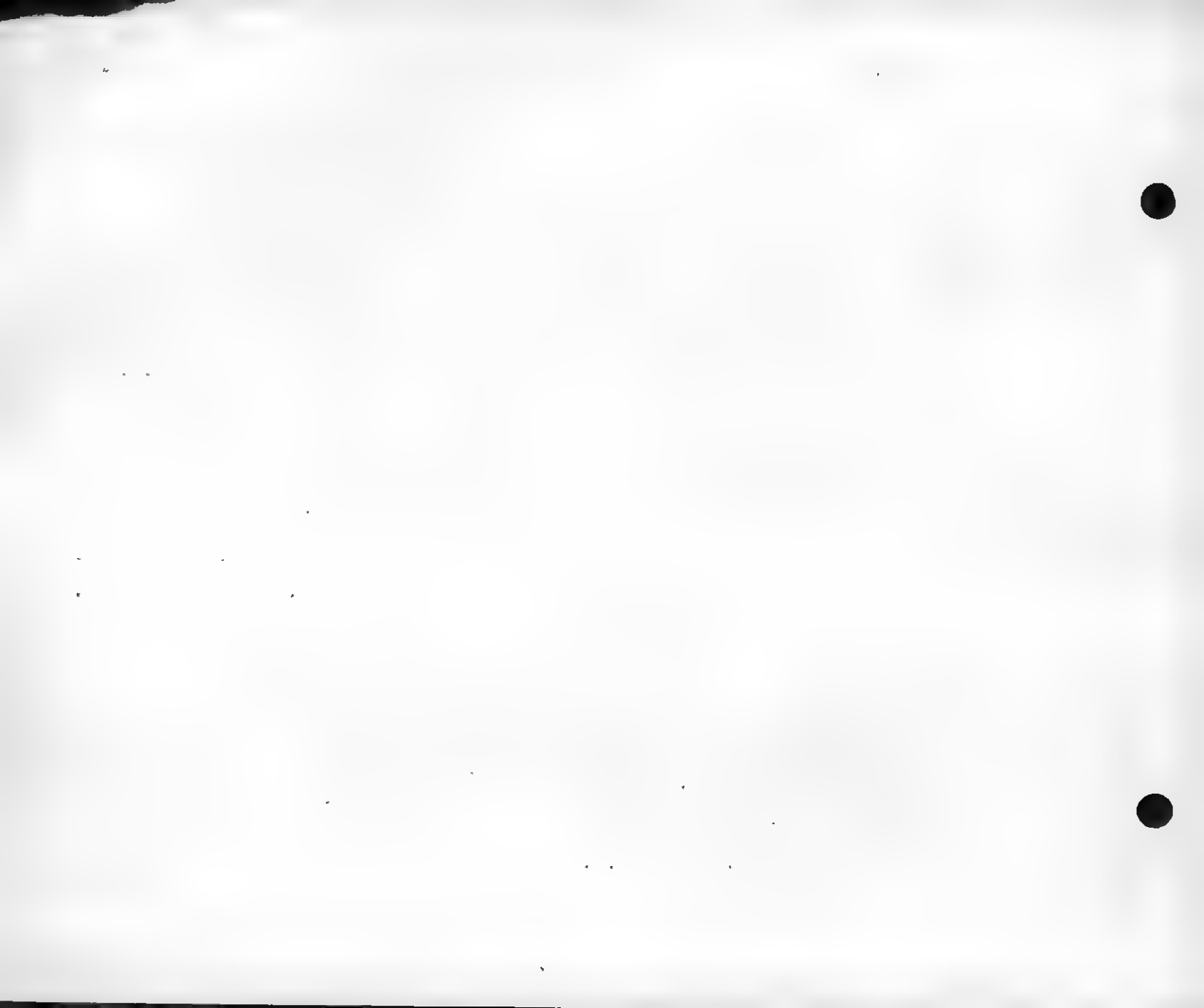
15052

## CERTIFICATE OF DEATH

15055

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Baltimore</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u> c. LENGTH OF STAY IN 1b <u>20 days</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chapel Oaks</u> d. STREET ADDRESS <u>5706 Nye Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <u>Butler Nash</u>		<b>4. DATE OF DEATH</b> Month Day Year <u>November 12 19 67</u>			
<b>5. SEX</b> <u>Male</u>	<b>6. COLOR OR RACE</b> <u>Negro</u>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>10/27/1909</u>		
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Unknown</u>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Abyville, South Carolina</u>			
<b>13. FATHER'S NAME</b>		<b>14. MOTHER'S MAIDEN NAME</b>			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b> <u>247-18-8352</u>			
<b>17. INFORMANT</b> Address <u>Records: Spring Grove State Hospital</u>		<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Myocardial Infarction, acute, probable</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Cardiovascular Ht. Dis</u> DUE TO (c) <u>Arteriosclerosis, generalized, senile</u>		INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs.</u> <u>unk.</u> <u>unk.</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Chronic Brain Syndrome associated with I.C. above.</u>					
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)			
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. 19	<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)	<b>20f. (City or town) (County) (State)</b>		
<b>21. I certify that</b> <del>NO</del> (this hospital) attended the deceased from <u>10/23/ 1967</u> , to <u>11/12, 1967</u> , that <del>he</del> (we) last saw the deceased alive on <u>Nov. 12 19 67</u> , and that death occurred at <u>8:50</u> M, from causes and on the date stated above.					
<b>22a. SIGNATURE</b> <u>Anthony J. Young, M.D.</u>		<b>22b. DATE SIGNED</b> <u>11-13-67</u>			
<b>22c. PHYSICIAN'S NAME</b> (Type) <u>Anthony J. Young, M.D.</u>		<b>22d. ADDRESS</b> <u>Spring Grove State Hospital</u> <u>Baltimore, Maryland 21228</u>			
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Removal</u>	<b>23b. DATE THEREOF</b> <u>11/18/67</u>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Harmony Mem. PK.</u>	<b>23d. LOCATION</b> (City or Town) (County) (State) <u>Randover, Md</u>		
<b>24. FUNERAL DIRECTOR</b> ADDRESS <u>Joseph J. Locke Jr. 13042 Central Ave. Balb.</u>		<b>25a. REC'D BY REGISTRAR</b> DATE <u>NOV 14 1967</u>			
<b>25b. REGISTRAR'S SIGNATURE</b> <u>Charles Judge</u>		<b>25c. REGISTRAR'S SIGNATURE</b> <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 7 61

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
15053  
15056

1. PLACE OF DEATH a. COUNTY <b>Balto.</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <b>Md.</b> <b>20910</b> <b>Montgomery</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Shangri-La Nursing Home</b>		e. STREET ADDRESS <b>8600 16 th. Street</b>	
3. NAME OF DECEASED (Type or print) <b>Emma</b>		4. DATE OF DEATH <b>November 4 1967</b>	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>July 11, 1883</b>	
9. AGE (In years last birthday) <b>84 yrs</b>		10. IF UNDER 1 YEAR Months Days	
11. IF UNDER 24 HRS. Hours Min		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Meier Meyer</b>		14. MOTHER'S MAIDEN NAME <b>Henriette Klein</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>063-18-3011D</b>	
17. INFORMANT <b>Mr. Benno Nathan</b>		Address <b>Silver Spring Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cardio Respiratory failure</b> 7 ) <b>Acidosis, dehydration, uremia</b> DUE TO <b>Advanced generalized arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, } DUE TO <b>Decubitus Ulcerations</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
21. TIME OF INJURY Month, Day Year Hour a.m. p.m. <b>19</b>		22d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
22c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		22f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>April 1967</b> to <b>4 Nov. 1967</b> , that (I) (we) last saw the deceased alive on <b>4 Nov. 1967</b> , and that death occurred <b>2 days</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>William J. Bryson</b>		22b. DATE SIGNED <b>5 Nov. 67</b>	
22c. PHYSICIAN'S NAME (Type) <b>William J. BRYSON</b>		22d. ADDRESS <b>4605 Edmondson Ave 29</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <b>11/6/1967</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Beth Israel Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Woodbridge New Jersey</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. J. Tidwell &amp; Sons</b>		25a. REC'D BY REGISTRAR <b>NOV 8 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)  
25M 1/67

<div style="display: flex; justify-content: space-between;"> <div> <p>15054</p> </div> <div> <p>MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 Item # 2 Film G595 11/24/67</p> </div> <div> <p>15057</p> </div> </div>											
<b>1 PLACE OF DEATH</b> a. COUNTY <b>BALTIMORE</b> MARYLAND						<b>2 USUAL RESIDENCE</b> (Where deceased lived, if institution Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b>					
b. CITY OR TOWN (If outside corporate limits, give RURAL and give nearest town) <b>GARRISON</b>				c. LENGTH OF STAY IN 1b <b>3 YRS 14 DMS</b>		c. CITY OR TOWN (If outside of corporate limits, give RURAL and give nearest town) <b>Baltimore 1216 Greenway Apts.</b>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>FOXLEIGH NURSING HOME GARRISON M.D.</b>						d. STREET ADDRESS <b>401 N. Charles St.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <b>IDA</b>						First Middle Last <b>NEUMAN</b>		<b>4 DATE OF DEATH</b> Month <b>11</b> Day <b>14</b> Year <b>1967</b>			
<b>5. SEX</b> <b>FEMALE</b>		<b>6 COLOR OR RACE</b> <b>WHITE</b>		<b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8 DATE OF BIRTH</b> <b>3/3/73</b>		<b>9 AGE</b> (In years last birthday) <b>94</b> yrs		<b>IF UNDER 1 YEAR</b> Months Days Hours Min <b>IF UNDER 24 HRS</b>	
<b>10a USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>TEACHER</b>				<b>10b KIND OF BUSINESS OR INDUSTRY</b> <b>Balt. City</b>		<b>11 BIRTHPLACE</b> (County & State, or foreign country) <b>BALTIMORE MD</b>				<b>12 CIT ZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>	
<b>13. FATHER'S NAME</b> <b>WILLIAM A F NEUMAN</b>						<b>14 MOTHER'S MAIDEN NAME</b> <b>ALICE SCHRIEBER</b>					
<b>15 WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>				<b>16 SOCIAL SECURITY NO.</b> <b>220-46-5550</b>		<b>17. INFORMANT</b> Address <b>Makesha Philpot Mount Ave, Phoenix, Md</b>					
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>771X Bronchial Pneumonia</b> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO (c) _____											
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Generalized Arteriosclerosis</b>										<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>20a ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER)				<b>20b DESCRIBE HOW INJURY OCCURRED</b> (Enter nature of injury in Part I or Part II of item 18)							
<b>20c TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <b>1967</b>				<b>20d INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f (City or town)</b> (County) (State)			
<b>21. I certify that (1) (this hospital) attended the deceased from Oct 1964, to 11-14, 1967, that (1) (we) last saw the deceased alive on 11-14, 1967, and that death occurred at 10 PM, from causes and on the date stated above.</b>											
<b>22a SIGNATURE</b> <b>David L. Miller</b> M.D.						<b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>		<b>22b DATE SIGNED</b> <b>11-14-67</b>			
<b>22c. PHYSICIAN'S NAME (Type)</b> <b>David L. Miller</b>						<b>22d ADDRESS</b> <b>Linson Rd</b>					
<b>23a BURIAL, CREMATION, REMOVAL (Specify)</b> <b>BURIAL</b>		<b>23b DATE THEREOF</b> <b>11-17-67</b>		<b>23c NAME OF CEMETERY OR CREMATORY</b> <b>Poplar Grove Cemetery</b>				<b>23d LOCATION (City or Town)</b> (County) (State) <b>Cockeysville Md.</b>			
<b>24. FUNERAL DIRECTOR</b> <b>Wm. Cook-Brooks Towson Inc.</b>						<b>ADDRESS</b> <b>1050 YORK Rd. Towson, Md. 21204</b>		<b>25a REC'D BY REGISTRAR</b> <b>NOV 20 1967</b>		<b>25b REGISTRAR'S SIGNATURE</b> <b>Judge</b>	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15055

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15058

1 PLACE OF DEATH a COUNTY <b>Baltimore</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) a STATE <b>Maryland</b> b COUNTY <b>Baltimore</b>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>		c LENGTH OF STAY IN 1b	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>700 Quad Ave.</b>		e STREET ADDRESS <b>7010 Dunbar Road</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Claude Edward Norman</b>		4 DATE OF DEATH Month Day Year <b>November 7 1967</b>	
5 SEX <b>MALE</b>	6 COLOR OR RACE <b>WHITE</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>MAY 20, 1945</b>
9 AGE (In years last birthday) <b>22 yrs</b>		10 IF UNDER 1 YEAR Months Days	11 IF UNDER 24 HRS Hours Min
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LABOR</b>		10b KIND OF BUSINESS OR INDUSTRY <b>SALVAGE Co.</b>	
11 BIRTHPLACE (State or foreign country) <b>HARTFORD COUNTY MD.</b>		12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13 FATHER'S NAME <b>WALTER NORMAN</b>		14. MOTHER'S MAIDEN NAME <b>MARY SEXTON</b>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO	
17. INFORMANT <b>Address</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Electrocution</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a EXTERNAL CAUSE WAS PRINCIPAL OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> PRINCIPAL <input type="checkbox"/> CONTRIBUTING		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <b>Subject came into indirect contact with high tension wire.</b>	
20c TIME OF INJURY Month, Day, Year Hour <b>3:30</b> pm <b>11 7 1967</b>		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Roadway</b>		20f (City or town) (County) (State) <b>Essex Balto. Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Edward F. Wilson</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Edward F. Wilson, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
		Address (Street, city, town, or county) <b>November 8, 1967</b>	
23a BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b DATE THEREOF <b>NOV. 10, 1967</b>	
23c NAME OF CEMETERY OR CREMATORY <b>NICKS CREEK COMMUNITY CEMETERY</b>		23d LOCATION (City or Town) (County) (State) <b>ATKINS VA.</b>	
24 FUNERAL DIRECTOR <b>HUBBARD FUNERAL HOME</b>		25a REC'D BY REGISTRAR <b>NOV 10 1967</b>	
		25b REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



15055

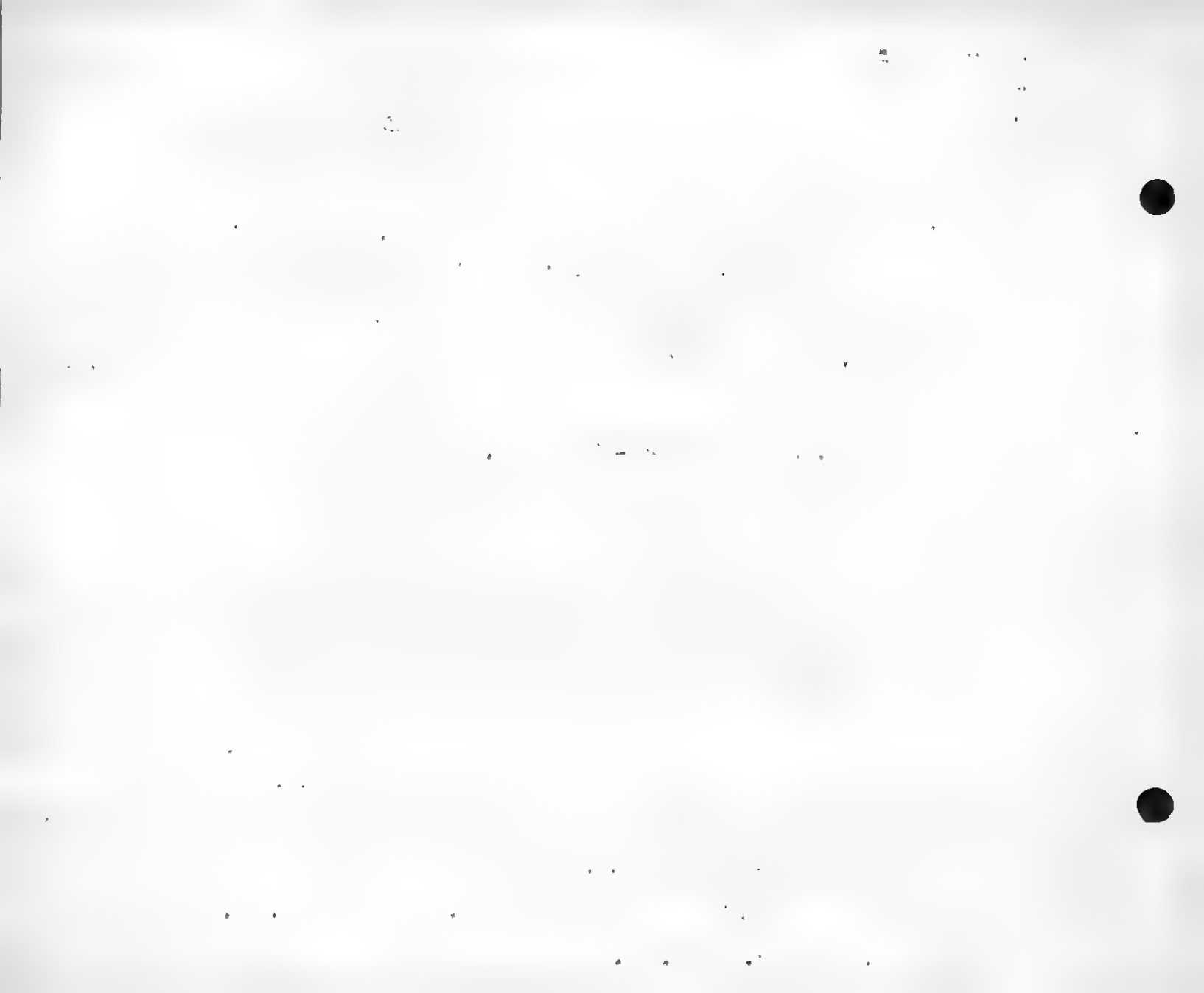
CERTIFICATE OF DEATH

15059

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>TOWSON</b> c. LENGTH OF STAY IN 1b <b>15</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>ST. JOSEPH HOSPITAL</b>		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>7902 OLD HARFORD RD. #21234</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>THOMAS J. P. O'BRIEN</b>		4. DATE OF DEATH Month Day Year <b>NOVEMBER 20 1967</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>24 NOVEMBER 23, 1896</b>
9. AGE (In years last birthday) <b>70 yrs</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Patent Atty.</b>	
10b. KIND OF BUSINESS OR INDUSTRY <b>Law</b>		11. BIRTHPLACE (County & State, or foreign country) <b>CHICAGO, ILLINOIS</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Peter O'Brien</b>	
14. MOTHER'S MAIDEN NAME <b>Elizabeth Walsh</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>yes W.W.I</b>	
16. SOCIAL SECURITY NO <b>212-01-2326</b>		17. INFORMANT <b>Mrs. Cecelia O'Brien</b> Address <b>same</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CEREBRAL THROMBOSIS</b> DUE TO (b) <b>SECONDARY TO ARTERIOSCLEROSIS</b> DUE TO (c) <b>ARTERIOSCLEROTIC HEART DISEASE</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>EMPHYSEMA</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>	
20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <b>NOVEMBER 19, 1967</b> , to <b>NOVEMBER 20, 1967</b> that (I) (we) last saw the deceased alive on <b>NOVEMBER 20, 1967</b> , and that death occurred at <b>5:00 A.M.</b> from causes and on the date stated above	
22a. SIGNATURE <i>Gualberto E. Gokim, Jr.</i> M.D.		22b. DATE SIGNED <b>NOVEMBER 20, 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>GUALBERTO GOKIM, M.D.</b>		22d. ADDRESS <b>7620 YORK ROAD TOWSON, MARYLAND</b>	
23a. BURIAL, CREMATION, or other disposition (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11/24/67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer Cem.</b>		23d. LOCATION (City or Town) (County) (State) <b>Balto. Md.</b>	
24. FUNERAL DIRECTOR <b>Leonard J. Ruck Inc., Balto. Md.</b>		25a. REC'D BY REGISTRAR <b>NOV 21 1967</b>	
25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the medical director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1 PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Balto</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Parkville</b>				c. LENGTH OF STAY IN IL <b>31, yrs.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>9508 Powderhorn road</b>						d. STREET ADDRESS <b>730 Aldworth road</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <b>GERTRUDE M. O'CONNOR</b>						4 DATE OF DEATH <b>Nov. 28 19 67</b>					
5 SEX <b>F</b>		6. COLOR OR RACE <b>W</b>		7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH <b>April 8 1884</b>		9. AGE (in years last birthday) <b>83 yrs</b>		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>at home</b>				10b. KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (County & State, or foreign country) <b>Penn.</b>				12 CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Alfred DuPont Henbis</b>						14. MOTHER'S MAIDEN NAME <b>Lucy A. Thomas</b>					
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>214-56-6790</b>		17 INFORMANT <b>Family Records</b>		Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cerebral thrombosis, left hemiplegia</b> <b>332x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>arteriosclerosis, generalized</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>2 months</b>											
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (the hospital) attended the deceased from <b>Oct 10, 1967</b> to <b>Nov. 28, 1967</b> , that (I) (we) last saw the deceased alive on <b>Nov. 28, 1967</b> , and that death occurred at <b>10:25 PM</b> , from causes and on the date stated above											
22a. SIGNATURE <i>E. J. Alessi</i>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>12/1/67</b>			
22c. PHYSICIAN'S NAME (Type) <b>E. J. ALESSI, MD.</b>						22d. ADDRESS <b>6217 Harford road</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12/2/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Parkwood Cem.</b>				23d. LOCATION (City or Town) (County) (State) <b>Balto Co Md.</b>			
24. FUNERAL DIRECTOR <b>C.F. EVANS &amp; SON 8802 Harford road</b>						25a. RECEIVED BY REG. STRAP DATE <b>DEC 4 1967</b>		25b. REGISTRAR'S SIGNATURE <i>Charles J. J...</i>			



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VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1 PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND						2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>QUEEN ANNE</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>				c. LENGTH OF STAY IN 1b <b>7 DAYS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>GRAYSONVILLE</b>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>VETERANS ADMINISTRATION HOSPITAL</b>						d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print)			First <b>HARRY</b> Middle <b>-</b> Last <b>O'DONNELL</b>			4 DATE OF DEATH			Month <b>NOVEMBER</b> Day <b>9</b> Year <b>19 67</b>		
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>AUGUST 3, 1889</b>		9. AGE (In years last birthday) yrs. <b>78</b>		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>INSPECTOR, OF OYSTERS STATE OF MARYLAND</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>GRAYSONVILLE, MARYLAND</b>				11. BIRTHPLACE (County & State, or foreign country) <b>U.S.A.</b>			
13. FATHER'S NAME <b>THOMAS O'DONNELL</b>						14. MOTHER'S MAIDEN NAME <b>MARTHA HORNEY</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>YES WW I</b>				16. SOCIAL SECURITY NO. <b>217 54 06 25</b>		17. INFORMANT Address <b>CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4200 CONGESTIVE HEART FAILURE</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>ARTERIOSCLEROTIC HEART DISEASE</b> DUE TO (c)											
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I, or Part II of item 18)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (X) (this hospital) attended the deceased from <b>11/2/67</b> , 19__ to <b>11/9/67</b> , 19__, that (X) (we) lost saw the deceased alive on <b>11/9/67</b> , 19__, and that death occurred at <b>3:00PM</b> from causes and on the date stated above.											
22a. SIGNATURE <i>Conrado L. Mancao</i>						M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>11/9/67</b>			
22c. PHYSICIAN'S NAME (Type) <b>CONRADO L. MANCAO, M.D.</b>						22d. ADDRESS <b>VAH FORT HOWARD, MARYLAND</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>			23b. DATE THEREOF <b>Nov. 12</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Stevensville Cemetery</b>			23d. LOCATION (City or Town) (County) (State) <b>Stevensville, Maryland</b>			
24. FUNERAL DIRECTOR <i>Edgar L. Lane</i> <b>Lane Funeral Home</b>						ADDRESS <b>Stevensville, Maryland</b>		25a. REC'D BY REGISTRAR <b>NOV 14 1967</b>		25b. REGISTRAR'S SIGNATURE <i>Charles J. J...</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15059

15062

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> <span style="float: right;">MARYLAND</span>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>✓</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Woodlawn</u>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>1910 Greengage Road</u>				d. STREET ADDRESS <u>4019 Old York Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Ottoviano C. Ormanno</u>				4. DATE OF DEATH Month <u>November</u> Day <u>17</u> Year <u>1967</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/5/1874</u>		9. AGE (In years last birthday) yrs. <u>93</u>	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired-Shoemaker</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Own Business</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Italy</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Ormanno</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)			16. SOCIAL SECURITY NO. <u>218-54-3999</u>		17. INFORMANT <u>Mrs. Josephine C. Ormanno</u> Address <u>(Same)</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Heart Failure</u> DUE TO (b) <u>Bronchopneumonia</u> DUE TO (c) <u>  </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>491x</u>						INTERVAL BETWEEN ONSET AND DEATH <u>two days.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Senility</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)				
20c. TIME OF INJURY Month, Day, Year Hour <u>  </u> m. <u>  </u> p.m. <u>  </u> 19 <u>  </u>			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Nov. 16</u> , 19 <u>67</u> , to <u>Nov. 17</u> , 19 <u>67</u> , that (II) (we) last saw the deceased alive on <u>Nov. 17</u> , 19 <u>67</u> , and that death occurred at <u>4:30 P.M.</u> , from causes on and on the date stated above							
22a. SIGNATURE <u>Raul Lopez</u>				22b. ADDRESS <u>911 Rambling Drive, Catonsville, Md.</u>		22c. DATE SIGNED <u>Nov. 18, 1967</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>11/21/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer</u>		23d. LOCATION (City or Town) (County) (State) <u>Baltimore Md.</u>
24. FUNERAL DIRECTOR <u>H.W. Jenkins &amp; Sons Co. 4905 York Rd. Balto., Md. 21212</u>				25a. REC'D BY REGISTRAR DATE <u>NOV 20 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15062

CERTIFICATE OF DEATH

15063

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institut an Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>city</b> <b>Pa</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>GARRISON</b>		c. LENGTH OF STAY IN lb <b>9 DAYS</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Foxleigh Nursing Home Garrison Md</b>				e. STREET ADDRESS <b>705 Sturgis Pl.</b>		f. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Julia</b>				4. DATE OF DEATH Month <b>11</b> Day <b>23</b> Year <b>19 67</b>			
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5/2/91</b>	9. AGE (In years last birthday) <b>76</b> yrs	IF UNDER 1 YEAR Months Days Hours Min	F UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		BIRTHPLACE (County & State, or foreign country) <b>Poland</b>		2. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Pieklo</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO <b>179-09-3802D</b>		17. INFORMANT <b>Kepp Funeral Home, 416 S. Main St. Pa.</b>		Address <b>Phoenixville</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY <b>4200</b> IMMEDIATE CAUSE (a) <b>arteriosclerotic heart disease</b> DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>few years</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, offce bldg etc)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>1966</b> , to <b>May 23 1967</b> , that (I) (we) last saw the deceased alive on <b>Nov 22 1967</b> , and that death occurred at <b>2:15 PM</b> , from causes and on the date stated above							
22a. SIGNATURE <b>Paul H Royse</b>				ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED <b>Nov 23 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>PAUL H ROYSE</b>				22d. ADDRESS <b>1403 Foley's La Pikesville, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>11-27-1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Holy Trinity Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Phoenixville, Pa.</b>	
24. FUNERAL DIRECTOR <b>Howard H. Hubbard, 4107 Wilkens Ave. 21227</b>				25a. REC'D BY REG STRAR DATE <b>NOV 24 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Pharies Judge</b>	



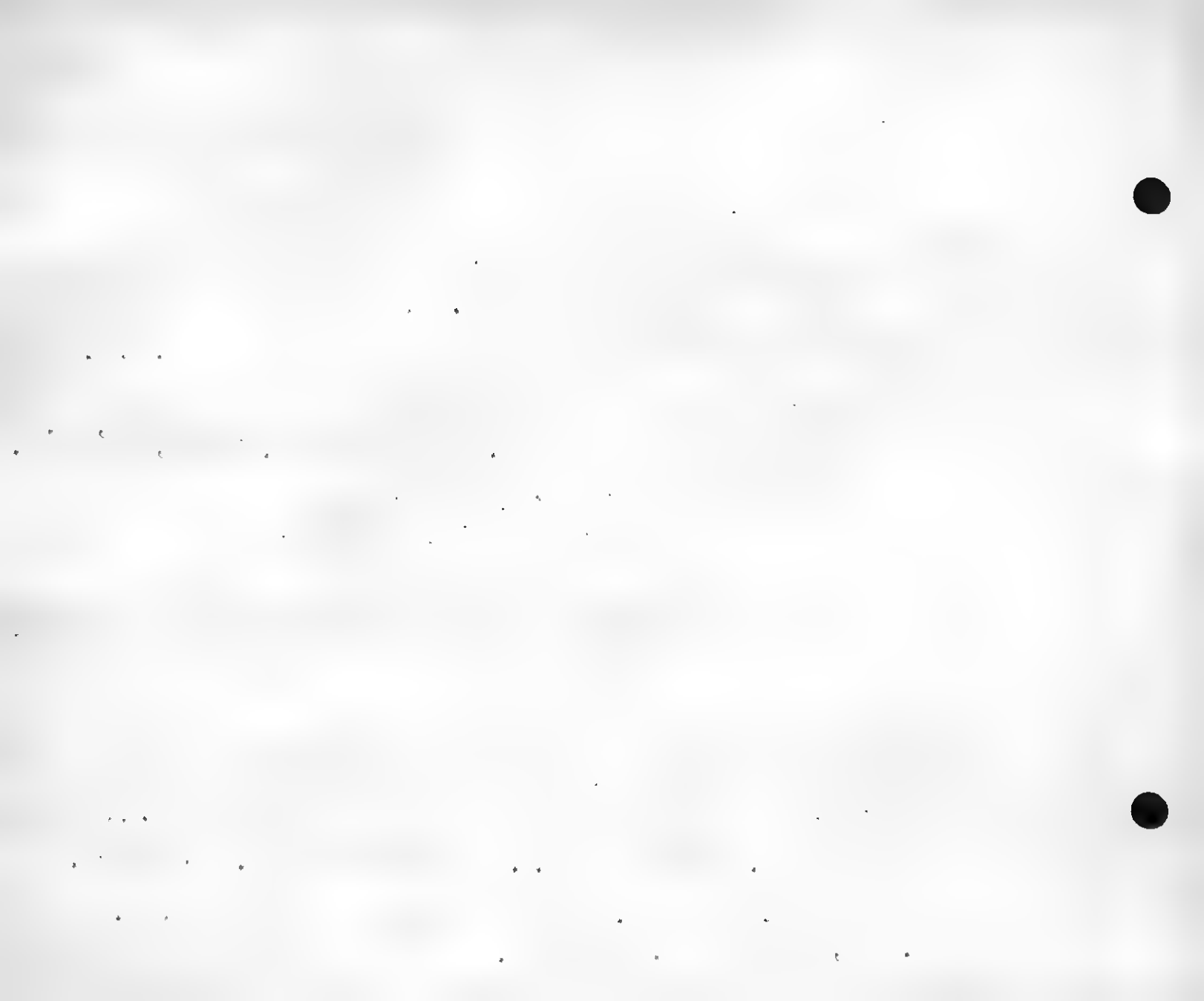


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VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Edgemere</b> c. LENGTH OF STAY IN 1b <b>44 Years</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Box 272 Dogwood Road</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Edgemere</b> d. STREET ADDRESS <b>Box 272 Dogwood Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <b>Katherine</b> Middle <b>Pabich</b> Last <b>Pabich</b>			4. DATE OF DEATH Month <b>November</b> Day <b>1</b> Year <b>1967</b>						
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Nov. 14, 1886</b>		9. AGE (in years last birthday) <b>80</b> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Germany</b>			12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Martin Tomczewski</b>					14. MOTHER'S MAIDEN NAME <b>Elizabeth Tabat</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes give war or dates of service)			16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT (Son) <b>Mr. Bernard Pabich Sr.</b> Address <b>Edgemere, Md. Box 272, Dogwood Rd.</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral hemorrhage</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <b>Arteriosclerotic C.V. disease</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								INTERVAL BETWEEN ONSET AND DEATH <b>10 days</b> <b>8 yrs.</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <b>Oct. 10, 1967</b> to <b>Nov. 1, 1967</b> , that (I) (we) last saw the deceased alive on <b>Oct. 31, 1967</b> , and that death occurred at <b>4 A.</b> M. from the causes and on the date stated above.									
22a. SIGNATURE <b>Louis N. Tollin</b>					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>Nov. 1, 1967</b>		
22c. PHYSICIAN'S NAME (Type) <b>Louis N. Tollin</b> M.D.					22d. ADDRESS <b>21219 6908 North Point Rd. Edgemere, Md.</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11/3/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Stanislaus Cemetery</b>			23d. LOCATION (City, town or county) (State) <b>Baltimore, Md.</b>		
24. FUNERAL DIRECTOR <b>John J. Duda, 7922 Wise Ave. Dundalk, Md.</b>					25a. REC'D BY REGISTRAR <b>NOV 6 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15062

15065

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mount Wilson</b> c. LENGTH OF STAY IN 1b <b>2 months, 4 days</b>		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>MD</b> b. COUNTY <b>Anne Arundel</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glenn Burnie</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Mount Wilson State Hospital</b>		d. STREET ADDRESS <b>Box 318, Rt 1</b> e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>THOMAS PEARMON</b>		4. DATE OF DEATH Month Day Year <b>11 - 29 1967</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7/19/1914</b>
9. AGE (In years last birthday) <b>53 yrs</b>		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>Anne Arundel Co, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William Pearmon</b>		14. MOTHER'S MAIDEN NAME <b>Lora Pearmon</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO <b>215-07-6757</b>	
17. INFORMANT <b>Records, Mt. Wilson State Hospital</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH CAUSED BY IMMEDIATE CAUSE (a) <b>Ca of the Brain, metastatic</b> DUE TO (b) <b>Ca of the Lung, Rt</b> DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Pulmonary emphysema, minimal.</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>9/25/67</b> , to <b>11/29/1967</b> that (I) (we) lost saw the deceased alive on <b>11/29/1967</b> , and that death occurred at <b>1:35 P.M.</b> from causes and on the date stated above			
22a. SIGNATURE <b>W. Newcomer</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Typed) <b>Wm. Newcomer, M.D., Superintendent</b>		22d. ADDRESS <b>Mount Wilson, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>12-2-67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>HAL'S CHURCH CEM.</b>		23d. LOCATION (City or Town) (County) (State) <b>MARLEY NECK Md</b>	
24. FUNERAL DIRECTOR <b>I. L. BROWN + SON</b>		25a. REC'D BY REGISTRAR <b>DEC 4 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>J. L. Brown</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Stoneleigh</b>		c. LENGTH OF STAY IN 1b <b>03</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>6608 Raven Hill Road</b>		d. STREET ADDRESS <b>6608 Raven Hill Road</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>KATHRYN F. PELTZ</b>		4. DATE OF DEATH Month Day Year <b>Nov. 1, 19 67</b>	
5. SEX <b>Felame</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 9, 1898</b>
9. AGE (in years last birthday) <b>68</b> yrs		10. UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>At home</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Henry J. Faul</b>		14. MOTHER'S MAIDEN NAME <b>Anna Elizabeth Grinnell</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO	
17. INFORMANT <b>William F. Peltz 6608 Raven Hill Road</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Advanced CA of the left breast with/metastases</b> DUE TO (b) <b>to lungs; pleura and spine</b> DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
INTERVAL BETWEEN ONSET AND DEATH <b>2 years</b>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1B)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____ M., from causes and on the date stated above			
22a. SIGNATURE <b>Robert C. Kimberly</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>Robert C. Kimberly, M.D.</b>		22d. ADDRESS <b>103 E. Chase St.,</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Entombment</b>	23b. DATE THEREOF <b>11/4/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Lorraine Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Woodlawn, Md.</b>
24. FUNERAL DIRECTOR <b>Ulrich Funeral Home 4210 Belair Road.</b>		25a. REC'D BY REGISTRAR DATE <b>NOV 6 1967</b>	
		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>	

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15  
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

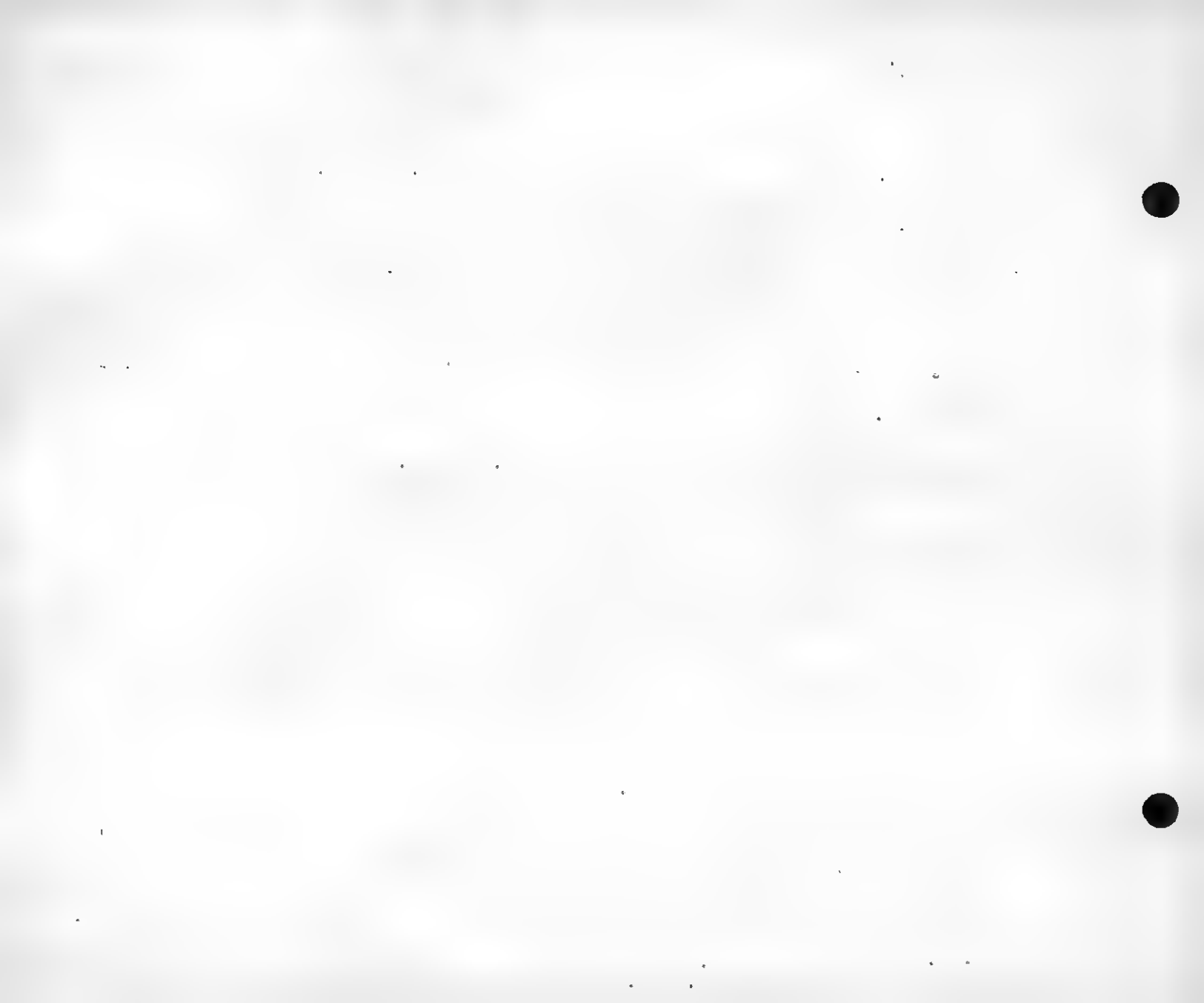
15064

CERTIFICATE OF DEATH

15007

1 PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>		c. LENGTH OF STAY IN 1b <b>11/27/67</b>		2. USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore 21206</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>St. Joseph Hospital</b>				d. STREET ADDRESS <b>5614 Denwood Avenue</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <b>William Thorn Peters, Sr.</b>		4 DATE OF DEATH Month <b>November</b> Day <b>23</b> Year <b>1967</b>		5 SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH <b>Sept. 10, 1890</b>		9 AGE (In years last birthday) <b>77</b> yrs.		IF UNDER 1 YEAR Months <b>7</b> Days <b>13</b> Hours <b>19</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>retired - Salesman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Shoes</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>George V. Peters</b>				14. MOTHER'S MAIDEN NAME <b>Elizabeth Bond</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes WW I</b>		16. SOCIAL SECURITY NO. <b>WW I</b>		17. INFORMANT <b>Mrs. Mary C. Peters</b>		Address <b>(Same)</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Undetermined</b> DUE TO (b) <b>Chronic debilitation</b> DUE TO (c) <b>Osteoblastic sarcoma</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Nov. 16, 1967</b> , to <b>Nov. 23, 1967</b> , that (I) (we) last saw the deceased alive on <b>November 23, 1967</b> , and that death occurred at <b>3:30 AM</b> from causes and on the date stated above.							
22a. SIGNATURE <b>A. S. Sayoc</b>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>Nov. 23, 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>A. S. Sayoc</b>				22d. ADDRESS <b>7620 York Rd. 21204</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11/27/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Greenmount</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Md.</b>	
24. FUNERAL DIRECTOR <b>H. W. Jenkins &amp; Sons Co. 4905 York Road Balto., Md. 21212</b>				25a. REC'D BY REGISTRAR <b>NOV 27 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

MEDICAL CERTIFICATION





15065

CERTIFICATE OF DEATH

15068

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <b>Towson</b> c. LENGTH OF STAY IN 1b <i>Life</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Glen Arm</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Manor Rd.</b>	
3. NAME OF DECEASED (Type or print) <b>Christine</b> First Middle Last <b>POLSTON</b>		4. DATE OF DEATH Month Day Year <b>November 21, 1967</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 6, 1967</b>
9. AGE (in years last birthday) <b>8</b>		10. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. BIRTHPLACE (County & State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <i>John Polston</i>		14. MOTHER'S MAIDEN NAME <i>Beatrice Liddings</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>no</i>		16. SOCIAL SECURITY NO. <i>no</i>	
17. INFORMANT <i>John Polston - Glen Arm, Md.</i>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumothorax Atelectasis</b> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day Year Hour a.m. _____ p.m. _____ 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>11/20/</b> , 19 <b>67</b> , to <b>11/21/</b> , 19 <b>67</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>11/21/</b> , 19 <b>67</b> , and that death occurred at <b>4 P.M.</b> , from causes and on the date stated above.			
22a. SIGNATURE <i>Imelda Salanio</i>		22b. DATE SIGNED <b>November 21, 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>Imelda Salanio, M.D.</b>		22d. ADDRESS <b>7620 York Rd., Towson, Md. 21204</b>	
23a. BURIAL CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <b>11/25/67</b>	23c. NAME OF CEMETERY OR CREMATORY <i>St. Joseph</i>	23d. LOCATION (City or Town) (County) (State) <i>Liquor, Balto. Co. Md.</i>
24. FUNERAL DIRECTOR <i>Mr. L. Salanio</i>		25a. REC'D BY REGISTRAR <b>NOV 27 1967</b>	
25b. REGISTRAR'S SIGNATURE <i>John J. Salanio</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



CERTIFICATE OF DEATH

15066

15069

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>MD</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>GARRISON</b>		c. LENGTH OF STAY IN 1b <b>2 MO 26 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>FOREIGN NURSING HOME GARRISON MD</b>		d. STREET ADDRESS <b>3452 ELM AVE</b>	
3 NAME OF DECEASED (Type or print) First <b>WALTER</b> Middle <b>E.</b> Last <b>POOLE</b>		4 DATE OF DEATH Month <b>11</b> Day <b>20</b> Year <b>1967</b>	
5 SEX <b>MALE</b>	6 COLOR OR RACE <b>WHITE</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>6/22/81</b>
9 AGE (In years last birthday) yrs <b>86</b>		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>STATIONARY ENGINEER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>MARINE HOSPITAL</b>	
11 BIRTHPLACE (County & State, or foreign country) <b>MD.</b>		12 CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13 FATHER'S NAME <b>FRANCIS WASHINGTON POOLE</b>		14. MOTHER'S MAIDEN NAME <b>EMMA SMART</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16 SOCIAL SECURITY NO <b>217-20-7282</b>	
17 INFORMANT <b>Mr OSCAR POOLE, Son, ABOVE</b>		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> 4201 DUE TO (b) <b>Arteriosclerosis</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <b>11 hours</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (1) (this hospital) attended the deceased from <b>8-25</b> , 19 <b>67</b> , to <b>11-20</b> , 19 <b>67</b> , that (1) (we) last saw the deceased alive on <b>11-19</b> , 19 <b>67</b> , and that death occurred at <b>1:15 AM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>David J. Miller</b>		22b. DATE SIGNED <b>11-20-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>David J. Miller</b>		22d. ADDRESS <b>Linson Rd. Cuming Mills, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <b>11-22-67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Poplar Springs Meth.</b>	23d. LOCATION (City or Town) (County) (State) <b>Poplar Springs, Howard, Md.</b>
24 FUNERAL DIRECTOR <b>Arthur A. Haight</b>		25a. RECD BY REGISTRAR <b>Arthur A. Haight</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur A. Haight</b>		DATE <b>NOV 24 1967</b>	



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15067

1570

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Bureau, Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a COUNTY <u>BALTIMORE</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Res. denie before admission) a STATE <u>MARYLAND</u> b COUNTY <u>BALTIMORE</u>	
b CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>DUNDALK</u>		c LENGTH OF STAY in town <u>DUNDALK</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>3403 LIBERTY PARKWAY</u>		d STREET ADDRESS <u>3403 LIBERTY PARKWAY</u>	
3 NAME OF DECEASED (Type or print) <u>JOHN THOMAS POWELL</u>		4 DATE OF DEATH Month <u>NOV</u> Day <u>7</u> Year <u>1967</u>	
5 SEX <u>MALE</u>	6 COLOR OR RACE <u>WHITE</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>DEC 16-1887</u>
9 AGE (in years last birthday) <u>79</u> yrs		10 UNDER 24 HRS Months <u>7</u> Days <u>19</u> Hours <u>15</u> Min <u>61</u>	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>UMBERMAN</u>		10b KIND OF BUSINESS OR INDUSTRY <u>UMBER</u>	
11 BIRTHPLACE (State or foreign country) <u>NORTH CAROLINA</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13 FATHER'S NAME <u>WILLIAM POWELL</u>		14 MOTHER'S MAIDEN NAME <u>JANE BRADSHAW</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16 SOCIAL SECURITY NO <u>224-187397</u>	
17 INFORMANT <u>RALPH POWELL</u>		Address <u>3403 LIBERTY PARKWAY</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY <u>1561</u> IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO (c) <u>Cancer of Liver &amp; Met</u> INTERVAL BETWEEN ONSET AND DEATH			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I <u>HACD.</u>		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour <u>19</u> p.m.	20d INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e PLACE OF INJURY (Home, farm, factory, street, office, bldg, etc.)	20f (City or town) (County) (State)
21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Theodore C. Patterson</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>THEODORE C. PATTERSON, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		Address (Street, city, town, or county) <u>DUNDALK</u>	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b DATE THEREOF <u>11/10/67</u>	
23c NAME OF CEMETERY OR CREMATORY <u>CEPAR HILL</u>		23d LOCATION (City, town, or county) (State) <u>BIRZOOKLYN MD</u>	
24 FUNERAL DIRECTOR <u>ULLRICH FUNERAL HOME-DUNDALK MD</u>		25a REC'D BY REGISTRAR DATE <u>NOV 10 1967</u>	
		25b REGISTRAR'S SIGNATURE <u>Johnas J...</u>	



15071

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE  
HEALTH DEPT.

15068

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <u>Balto.</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution; Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Balto.</u>	
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>Lutherville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lutherville</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>1420 School La.</u>		d. STREET ADDRESS <u>1420 School La.</u>	
3 NAME OF DECEASED (Type or print) <u>ALBERT I. PURVINES</u>		4 DATE OF DEATH Month <u>11</u> Day <u>16</u> Year <u>1967</u>	
5 SEX <u>M</u>	6 COLOR OR RACE <u>N</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>1/18/93</u>
9 AGE (In years last birthday) <u>74</u> yrs		10 IF UNDER 1 YEAR Months <u>1</u> Days <u>19</u> HOURS <u>24</u> MIN <u>19</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Labourer (Retired)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>contractor</u>	
11 BIRTHPLACE (State or foreign country) <u>md.</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Samuel Purvine</u>		14 MOTHER'S MAIDEN NAME <u>Caroline Morris</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16 SOCIAL SECURITY NO. <u>217-01-7318</u>	
17 INFORMANT <u>Grant Purvine - 1420 School La. Lutherville</u>		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Gunshot wound of throat and</u> DUE TO (b) <u>Base of Brain</u> DUE TO (c) <u>Sudden</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II as item 18)	
20c. TIME OF INJURY Month, Day Year Hour <u>am</u> <u>pm</u> <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office building, etc.)	20f. (City or town) (County) (State)
21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Charles F. O'Donnell, M.D.</u>		22. DATE SIGNED <u>11/17/67</u>	
EXAMINER'S NAME (Type)		DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>11/20/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Pleasant Rest</u>	23d. LOCATION (City or town, County, State) <u>Towson, Balto. Co. Md.</u>
24. FUNERAL DIRECTOR <u>Wm. D. Chatman</u>		25a. REC'D BY REGISTRAR DATE <u>NOV 20 1967</u>	
ADDRESS <u>1701 M<sup>c</sup>Callister St. Balt., Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Judge</u>	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div style="text-align: center;"> <b>MARYLAND STATE DEPARTMENT OF HEALTH</b>  <b>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MD. 21201</b>  <b>CERTIFICATE OF DEATH</b> </div>											
<b>1. PLACE OF DEATH</b> a. COUNTY <b>Baltimore</b> <span style="float: right;">MARYLAND</span>						<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Reside in institution, give name and admission date) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>				c. LENGTH OF STAY IN 1b <b>Yrs.</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Texas</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>House in the Pines, Catonsville</b>						d. STREET ADDRESS <b>—</b>					
<b>3. NAME OF DECEASED</b> (Type or print) First <b>Michael</b> Middle <b>Carey</b> Last <b>Quinn</b>						<b>4. DATE OF DEATH</b> Month <b>November</b> Day <b>5</b> Year <b>1967</b>					
<b>5. SEX</b> <b>Male</b>		<b>6. COLOR OR RACE</b> <b>White</b>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>Apr. 30, 1897</b>		<b>9. AGE (in years last birthday)</b> <b>70 yrs.</b>		<b>IF UNDER 1 YEAR</b> Months Days Hours Min. <b>IF UNDER 24 HRS.</b>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Maintenance</b>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Seminary</b>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Maryland</b>			<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>		
<b>13. FATHER'S NAME</b> <b>John M. Quinn</b>						<b>14. MOTHER'S MAIDEN NAME</b> <b>Mary Elizabeth Fitzgerald</b>					
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>				<b>16. SOCIAL SECURITY NO.</b> <b>214-16-5979</b>		<b>17. INFORMANT</b> <b>John M. Quinn, Baltimore, Maryland 21234</b> Address <b>2600 Wentworth Road</b>					
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] <b>PART I. OATH WAS CAUSED BY:</b> IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> DUE TO (b) <b>Chronic Brain Syndrome</b> DUE TO (c) <b>Arteriosclerotic Cardio Vasc. Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>1 da.</b> <b>10 hr.</b> <b>10 yr.</b>	
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>											
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of Item 18.)							
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <b>19</b>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)			
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <b>8-2-1966</b> <b>to</b> <b>11-5-1967</b> , <b>that (I) (we) last saw the deceased alive on</b> <b>11-3-1967</b> , <b>and that death occurred at</b> <b>3:30 P.</b> <b>from the causes and on the date stated above.</b>											
<b>22a. SIGNATURE</b> <b>Wilmer K. Galtager</b>						<b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>M.D.</b> <b>22b. DATE SIGNED</b> <b>11-6-67</b>		<b>22c. PHYSICIAN'S NAME (Type)</b> <b>Wilmer K Galtager</b>		<b>22d. ADDRESS</b> <b>6209 Frederick Ave. Balt. 28, Md.</b>	
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>		<b>23b. DATE THEREOF</b> <b>Nov. 8, 1967</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>St. Joseph Cemetery</b>			<b>23d. LOCATION</b> (City, town or county) (State) <b>Texas, Maryland</b>				
<b>24. FUNERAL DIRECTOR</b> <b>Wm. Cook-Brooks Towson, 1050 York Road Towson, Maryland 21204</b>						<b>25a. REC'D BY REGISTRAR</b> <b>NOV 8 1967</b>		<b>25b. REGISTRAR'S SIGNATURE</b> <b>Charles Judge</b>			



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-1. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
GM 1/66

15070

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15073

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Owings Mills</b>		2. USUAL RESIDENCE (Where deceased lived f not inst in Residence before adm ssion) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) <b>Dundalk</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Rosewood State Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Gregory Webster RAWLINGS</b>		4. DATE OF DEATH Month Day Year <b>11 12 19 67</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1-18-53</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Dependent</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>none</b>	11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>
13. FATHER'S NAME <b>James Harris, Rawlings</b>		14. MOTHER'S MAIDEN NAME <b>Mary Catherine Sampson</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO <b>none</b>	17. INFORMANT Address <b>Rosewood Records, Owings Mills, Maryland</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Failure</b> <b>1542</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Congenital Heart Disease, Intra-auricular septal Defect</b> DUE TO (c) <b>14 yrs.</b>			INTERVAL BETWEEN ONSET AND DEATH <b>Terminal</b>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>9 years institutionalization, Mongolism</b>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspect an <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>D. D. Caples</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>D. D. Caples, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Nov. 10, 67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Rosewood Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Owings Mills, Md.</b>	
24. FUNERAL DIRECTOR <b>J. F. Eline &amp; Sons</b>		25a. REC'D BY REGISTRAR DATE <b>NOV 20 1967</b>	
ADDRESS <b>Reisterstown, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>William Judge</b>	

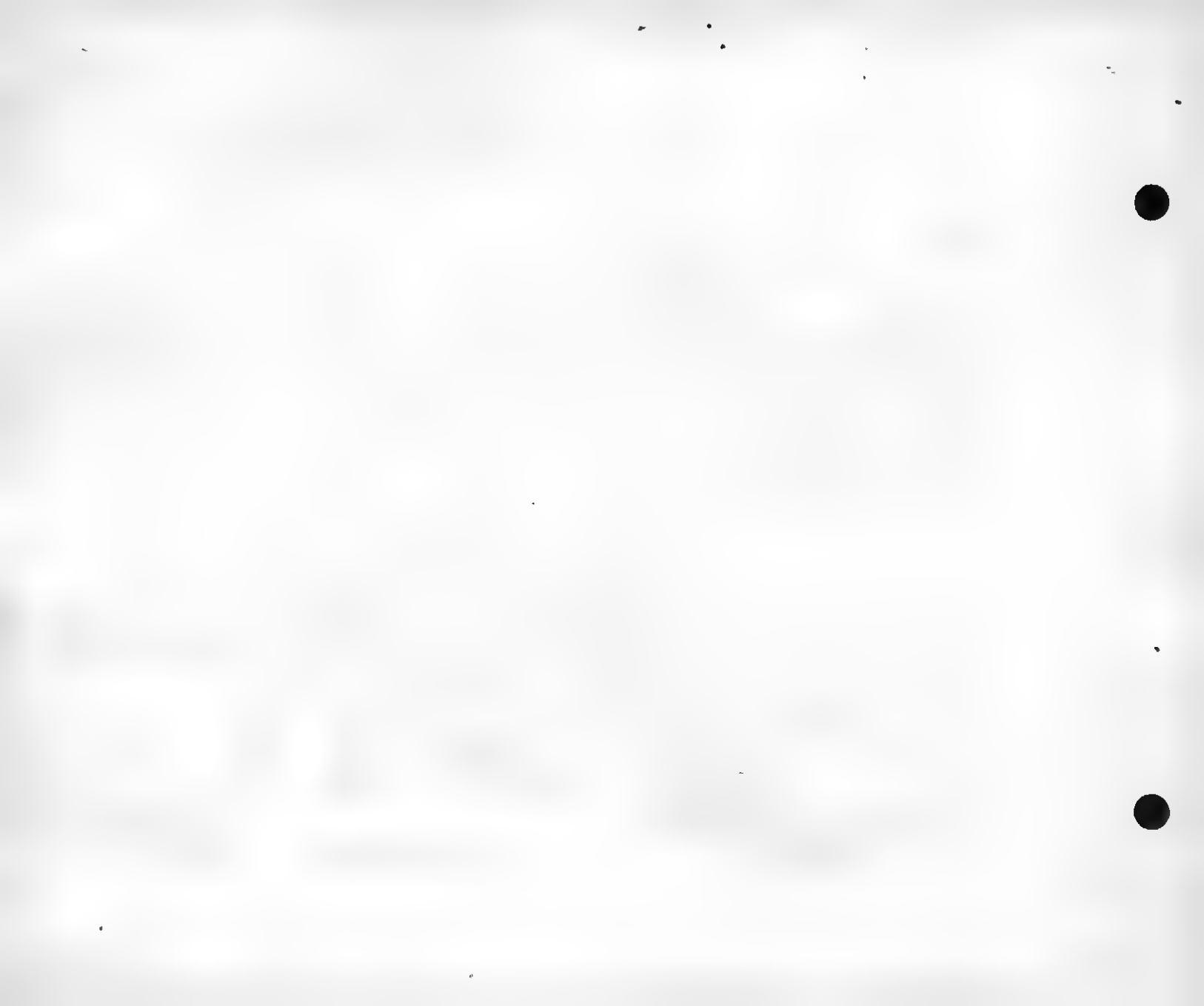


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
15072 CERTIFICATE OF DEATH 15074											
1 PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>				c. LENGTH OF STAY IN 1b <u>21 Days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Greater Baltimore Medical Center</u>						d. STREET ADDRESS <u>701 GlasGlow St</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <u>Edward George Redmer</u>						4 DATE OF DEATH Month <u>Nov</u> Day <u>8</u> Year <u>1967</u>					
5 SEX <u>M</u>		6 CO. OR OR RACE <u>Can</u>		7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH <u>5-21-13</u>		9 AGE (n years last birthday) <u>54</u> yrs		10 IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min <u>  </u>	
10a. USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Store Owner</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>  </u>		11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore</u>				12 CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13 FATHER'S NAME <u>Redmer, Albert</u>						14. MOTHER'S MAIDEN NAME <u>Fleischman</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>yes 42-45</u>				16 SOCIAL SECURITY NO <u>215-07-8523</u>		17. INFORMANT <u>Admission Information</u> Address <u>  </u>					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Carcinoma of lung with metastases</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>  </u> DUE TO (c) <u>  </u>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)				20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II at item 18) <u>  </u>							
20c TIME OF INJURY Month, Day Year <u>  </u> p.m. <u>  </u> 19 <u>  </u>				20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) <u>  </u>		20f (City or town) (County) (State) <u>  </u>			
21. I certify that (I) (this hospital) attended the deceased from <u>10/19/66</u> , 19 <u>66</u> , to <u>11/8</u> , 19 <u>66</u> that (I) (we) last saw the deceased alive on <u>11/8</u> , 19 <u>66</u> , and that death occurred at <u>4:30</u> M, from causes and on the date stated above											
22a SIGNATURE <u>Duncan McGuire</u>						M.D. ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22b DATE SIGNED <u>11/8/67</u>			
22c PHYSICIAN'S NAME (Type) <u>McGHEE</u>						22d ADDRESS <u>616, E. 34th St. Baltimore.</u>					
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE THEREOF		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)					
<u>Burial</u>		<u>Nov. 11, 1967</u>		<u>Dorchester Memorial Park, Cambridge Md.</u>		<u>  </u>					
24 FUNERAL DIRECTOR <u>Kenneth R. Thomas</u>						ADDRESS <u>Cambridge, Md.</u>		25a REC'D BY REGISTRAR <u>NOV 15 1967</u>		25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #2c & 1. Item #33/5 11/29/67 ph

CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. LENGTH OF STAY IN 1b <u>21228</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Shadynook Nursing Home</u>		e. STREET ADDRESS <u>1609 Frederick Rd.</u>	
3 NAME OF DECEASED (Type or print) First <u>Katherine</u> Middle <u>Rees</u> Last <u>Rees</u>		4 DATE OF DEATH Month <u>November</u> Day <u>18</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 1/94</u>
9. AGE (In years last birthday) <u>13</u> yrs		10. IF UNDER 1 YEAR Months <u>13</u> Days <u>13</u> Hours <u>13</u> Min <u>13</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Hutzel Bros.</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Balto., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Late - Wm. Hensel</u>		14. MOTHER'S MAIDEN NAME <u>Late - Elizabeth</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>215-09-2776</u>	
17. INFORMANT <u>L. Howland Rees</u>		Address <u>15 Dutton Ave. - 21228</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Terminal Bronchopneumonia</u> DUE TO <u>Progressive Parkinsonism</u> (b) <u>Chronic Brain Syndrome</u> DUE TO <u>Diabetes Mellitus</u> (c) <u>Diabetes Mellitus</u>			INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u> <u>5 years</u> <u>5 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour <u>a.m.</u> <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>January 4, 1964</u> , to <u>November 18, 1967</u> , that (I) (we) last saw the deceased alive on <u>11/18/67</u> 19 <u>67</u> , and that death occurred at <u>9:30AM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Emidio Bianco</u> M.D.		22b. DATE SIGNED <u>11/20/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Emidio Bianco, M.D.</u>		22d. ADDRESS <u>3350 Wilkens Ave.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>11/21/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cem.</u>	23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Md.</u>
24. FUNERAL DIRECTOR <u>Witzke F. D. - 4101 Edmondson Av.</u>		25a. REC'D BY REGISTRAR DATE <u>Nov 21 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	





MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15073

15076

1 PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Garrison</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Pikesville 8, Md.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Foxleigh Nursing Home, Garrison, Md.</b>		d. STREET ADDRESS <b>17 E. Sudbrook Lane</b>	
3 NAME OF DECEASED (Type or print) <b>Eva Cockey Register</b>		4. DATE OF DEATH Month <b>Nov.</b> Day <b>5,</b> Year <b>1967</b>	
5 SEX <b>Female</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>Oct. 22, 1887</b>
9 AGE (In years last birthday) <b>80</b> yrs		IF UNDER 1 YEAR Months <b>5,</b> Days <b>19</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Pikesville, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Thomas B. Cockey</b>		14. MOTHER'S MAIDEN NAME <b>Mary Warfield Cockey</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO <b>216-46-3912</b>	
17. INFORMANT <b>Mr. Henry Slicer Register, 17 E. Sudbrook Lane</b>		Address <b>Pikesville 8, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>cerebral vascular accident of hemiplegia and</b> DUE TO <b>diabetes mellitus</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>9 yrs</b> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>May, 1967</b> to <b>Nov. 5, 1967</b> that (I) (we) last saw the deceased alive on <b>Nov. 1, 1967</b> and that death occurred at <b>11:00 P.M.</b> from causes and on the date stated above.			
22a. SIGNATURE <b>Paul H. Royse</b>		22b. DATE SIGNED <b>11-6-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>PAUL H. ROYSE</b>		22d. ADDRESS <b>1403 FOLEY LANE PIKESVILLE MD</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>Nov. 8, 1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>St. Thomas Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Garrison, Balto. Md.</b>
24. FUNERAL DIRECTOR <b>Frank J. Kendall</b>		25a. REC'D BY REGISTRAR <b>NO 14 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 12 hours after death.

VR A111  
25M 1/6

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Parkville</b>		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Balto</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Parkville</b>	
c. LENGTH OF STAY IN 1b <b>57 yrs=</b>		d. STREET ADDRESS <b>2904 Linwood ave</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>2904 Linwood avenue</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <b>CONRAD RENNER</b>		4 DATE OF DEATH <b>Nov 24 1967</b>	
5 SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 30 1886</b>
9. AGE (In years less birthday) <b>81</b>		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Machinist</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Continental Can</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Germany</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO <b>215-03-3754</b>	
17. INFORMANT <b>Family records</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>331X Control hemorrhage</b> DUE TO (b) <b>Control extension</b> DUE TO (c) <b>Generalized extension</b>			INTERVAL BETWEEN ONSET AND DEATH <b>2 wks</b> <b>20 yrs</b> <b>25 yrs</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>April 1957</b> , to <b>Nov 1967</b> , that (I) (we) last saw the deceased alive on <b>11/24 1967</b> , and that death occurred at <b>7 PM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>[Signature]</b>		22b. DATE SIGNED <b>11/27/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>S.E. NARKIN</b>		22d. ADDRESS <b>8100 NARKIN RD</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>11/28/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Gardens of Faith</b>	23d. LOCATION (City or Town) (County) (State) <b>Balto. Co Md.</b>
24. FUNERAL DIRECTOR <b>C.F. EVANS &amp; SON 8802 Harford road</b>		25a. REC'D BY REGISTRAR <b>NOV 29 1967</b>	
		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	



15078

15075

## CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove for newspapers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>		c. LENGTH OF STAY IN 1b <b>45 DAYS</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>VETERANS ADMINISTRATION HOSPITAL</b>		e. STREET ADDRESS <b>324 LANGLEY ROAD</b>	
3 NAME OF DECEASED (Type or print) First <b>NELSON</b> Middle <b>F.</b> Last <b>RHINEHART</b>		4 DATE OF DEATH Month <b>NOVEMBER</b> Day <b>9</b> Year <b>67</b>	
5 SEX <b>MALE</b>	6 COLOR OR RACE <b>WHITE</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1/13/93</b>
9 AGE (In years last birthday) yrs <b>74</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>JANITOR</b>	11 BIRTHPLACE (County & State, or foreign country) <b>BALTIMORE, MARYLAND</b>
10b KIND OF BUSINESS OR INDUSTRY <b>MASONIC LODGE</b>		12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13 FATHER'S NAME <b>FRANK N. RHINEHART</b>		14 MOTHER'S MAIDEN NAME <b>ELIZABETH BIER</b>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>YES WW I</b>		16 SOCIAL SECURITY NO <b>218 10 21 68</b>	
17 INFORMANT <b>CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.</b>		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ADENOCARCINOMA OF THE GALL BLADDER</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <b>UNKNOWN</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTR BUT NG <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <b>19</b>	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f (City or town) (County) (State)
21 I certify that (this hospital) attended the deceased from <b>9/15/67</b> , 19____, to <b>11/9/67</b> , 19____, that (we) lost the deceased alive on <b>11/9/67</b> , 19____, and that death occurred at <b>6:30AM</b> from causes on and on the date stated above			
22a SIGNATURE <i>Pushpendra Senan</i>		22b DATE SIGNED <b>11/9/67</b>	
22c PHYSICIAN'S NAME (Type) <b>PUSHPENDRA SENAN, M. D.</b>		22d ADDRESS <b>VZH VAE FORT HOWARD, MARYLAND</b>	
23a BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>11/13/67</b>	23c NAME OF CEMETERY OR CREMATORY <b>BALTIMORE NATIONAL</b>	23d LOCATION (City or town) (County) (State) <b>BALTIMORE, MARYLAND</b>
24. FUNERAL DIRECTOR <i>Joseph N. Zannino</i>		25. REGISTERED BY <b>ZANNINO FUNERAL HOME</b>	
25. DATE <b>NOV 13 1967</b>		25. REGISTERED SIGNATURE <i>[Signature]</i>	
257 8. Conkling Street, Baltimore, Md.			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (Pages 1 and 2) and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15075

CERTIFICATE OF DEATH

15079

1 PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville, Maryland</b>		c. LENGTH OF STAY IN 1b <b>Baltimore # 34</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Spring Grove State Hospital</b>		d. STREET ADDRESS <b>3216 Texas Avenue</b>	
3 NAME OF DECEASED (Type or print) <b>Letha Mae Rice</b>		4 DATE OF DEATH Month <b>11</b> Day <b>22</b> Year <b>1967</b>	
5 SEX <b>Female</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>Aug. 2, 1897</b>
9 AGE (In years last birthday) <b>70</b> yrs.		10 IF UNDER 1 YEAR Months <b>22</b> Days <b>19</b> Hours <b>67</b>	
10a USUAL OCCUPATION (Give kind of work done during most of working season if retired) <b>None Housewife</b>		10b KIND OF BUSINESS OR INDUSTRY <b>At Home</b>	
11 BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12 CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13 FATHER'S NAME <b>Frank Dennison</b>		14 MOTHER'S MAIDEN NAME <b>Mary Hamilton</b>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16 SOCIAL SECURITY NO <b>217-10-7821</b>	
17 INFORMANT <b>Records: Spring Grove State Hospital</b>		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>R middle lobe pneumonia.</b> DUE TO (b) (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost DUE TO (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Cerebrovascular accident ass. with (L) hemiplegia.</b>			
19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that <b>it</b> (this hospital) attended the deceased from <b>July 10</b> , 1967, to <b>Nov 22</b> , 1967, that <b>it</b> (we) last saw the deceased alive on <b>11-22-1967</b> , and that death occurred at <b>10:30 P.M.</b> , from causes and on the date stated above.			
22a SIGNATURE <b>Ronald M. Sheets, M.D.</b>		22b. DATE SIGNED <b>11-23-1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>RONALD M. SHEETS, M.D.</b>		22d ADDRESS <b>Spring Grove State Hospital Baltimore, Maryland 21228</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <b>11/25/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Parkwood</b>	23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Md.</b>
24 FUNERAL DIRECTOR <b>Leonard J. Ruck, Inc 5305 Harford Rd</b>		25a REC'D BY REGISTRAR <b>DATE 11-24-1967</b>	
25b REGISTRAR'S SIGNATURE <b>Charles J. [Signature]</b>			





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

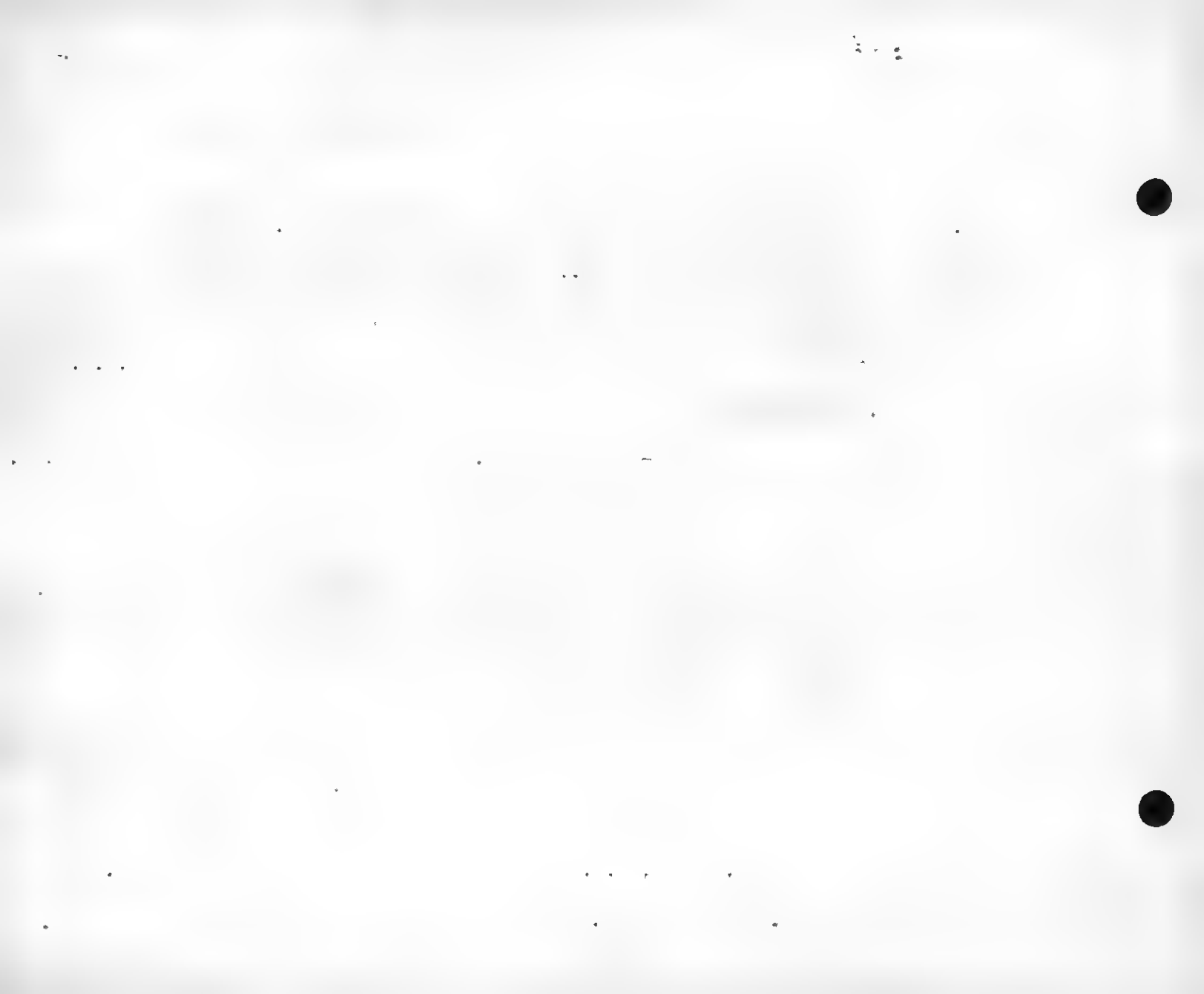
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>TOWSON</b> c. LENGTH OF STAY IN Tb		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>ST. JOSEPH HOSPITAL</b>		d. STREET ADDRESS <b>8117 GLEN GARY RD. #21234</b>	
3 NAME OF DECEASED (Type or print) First Middle Last <b>LOUISE E. RICHARDSON</b>		4 DATE OF DEATH Month Day Year <b>NOVEMBER 3 19 67</b>	
5 SEX <b>FEMALE</b>	6 COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>DECEMBER 25, 1888</b> 78 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (County & State, or foreign country) <b>Virginia</b>		12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>H. Clinton Bondar</b>		14. MOTHER'S MAIDEN NAME <b>Helen O'Connor</b>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>223-05-6937</b>	
17 INFORMANT <b>Mrs. Helen Le Grecko</b>		Address <b>Richmond, Va.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH CAUSED BY: <b>4330 IMMEDIATE CAUSE (a) CARDIO RESPIRATORY ARREST</b> DUE TO (b) <b>CEREBRAL THROMBOSIS</b> (c) <b>ARTERIOSCLERATIC CARDIO VASCULAR DISEASE</b>			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>October 8, 1967</b> , to <b>November 3, 1967</b> that (I) (we) last saw the deceased alive on <b>November 3, 1967</b> , and that death occurred at <b>12:35 AM</b> from causes and on the date stated above.			
22a. SIGNATURE <i>Beatriz P. Dizon</i> M.D.		22b. DATE SIGNED <b>NOVEMBER 3, 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>BEATRIZ P. DIZON, M.D.</b>		22d. ADDRESS <b>7620 YORK ROAD TOWSON, MD. #21204</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>Nov. 6, 1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Calvary</b>	23d. LOCATION (City or Town) (County) (State) <b>Richmond Va.</b>
24. FUNERAL DIRECTOR <i>Wm. J. Tickner &amp; Sons</i>		25a. REC'D BY REGISTRAR <i>Wm. J. Tickner &amp; Sons</i>	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		DATE <b>NOV 8 1967</b>	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15078

15081

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institut on Residence before adm ssion) a. STATE <b>MD.</b> b. COUNTY <b>BALTO.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CATONSVILLE</b>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>SNADY NODS NURSING HOME</b>		d. STREET ADDRESS <b>101 PARK DRIVE</b>	
3 NAME OF DECEASED (Type or print) <b>JOHN HARRY RICHTOR</b>		4. DATE OF DEATH <b>NOV. 28 1967</b>	
5 SEX <b>M</b>	6 COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8-31-1882</b>
9. AGE (In years last birthday) <b>85</b> yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SHIPPING</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>MD. RICHTOR CO.</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>MD</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>JAMUEL RICHTOR</b>		14. MOTHER'S MAIDEN NAME <b>IDA WALTZ</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO <b>213-16-9819</b>	
17. INFORMANT <b>Mrs Betty Belver, 101 Park Drive</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Arteriosclerotic Cardio-vascular Disease</b> <b>443X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <b>years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Essential Hypertension</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Port II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (the hospital) attended the deceased from <b>Sept.</b> , 19 <b>48</b> , to <b>Nov.</b> , 1967, that (I) (we) lost the deceased alive on <b>Nov. 28</b> , 19 <b>67</b> , and that death occurred at <b>1:05 PM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>Leo J. Gaver, M.D.</b>		22b. DATE SIGNED <b>11/29/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Leo J. Gaver, M.D.</b>		22d. ADDRESS <b>1 Mallow Hill Ave., Baltimore, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <b>12-1-67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Lorraine Mausoleum</b>	23d. LOCATION (City or Town) (County) (State) <b>Woodlawn Md.</b>
24. FUNERAL DIRECTOR <b>Farley-Covering A.F.W. Catonsville, Md.</b>		25a. REC'D BY REGISTRAR <b>DEC 4 1967</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

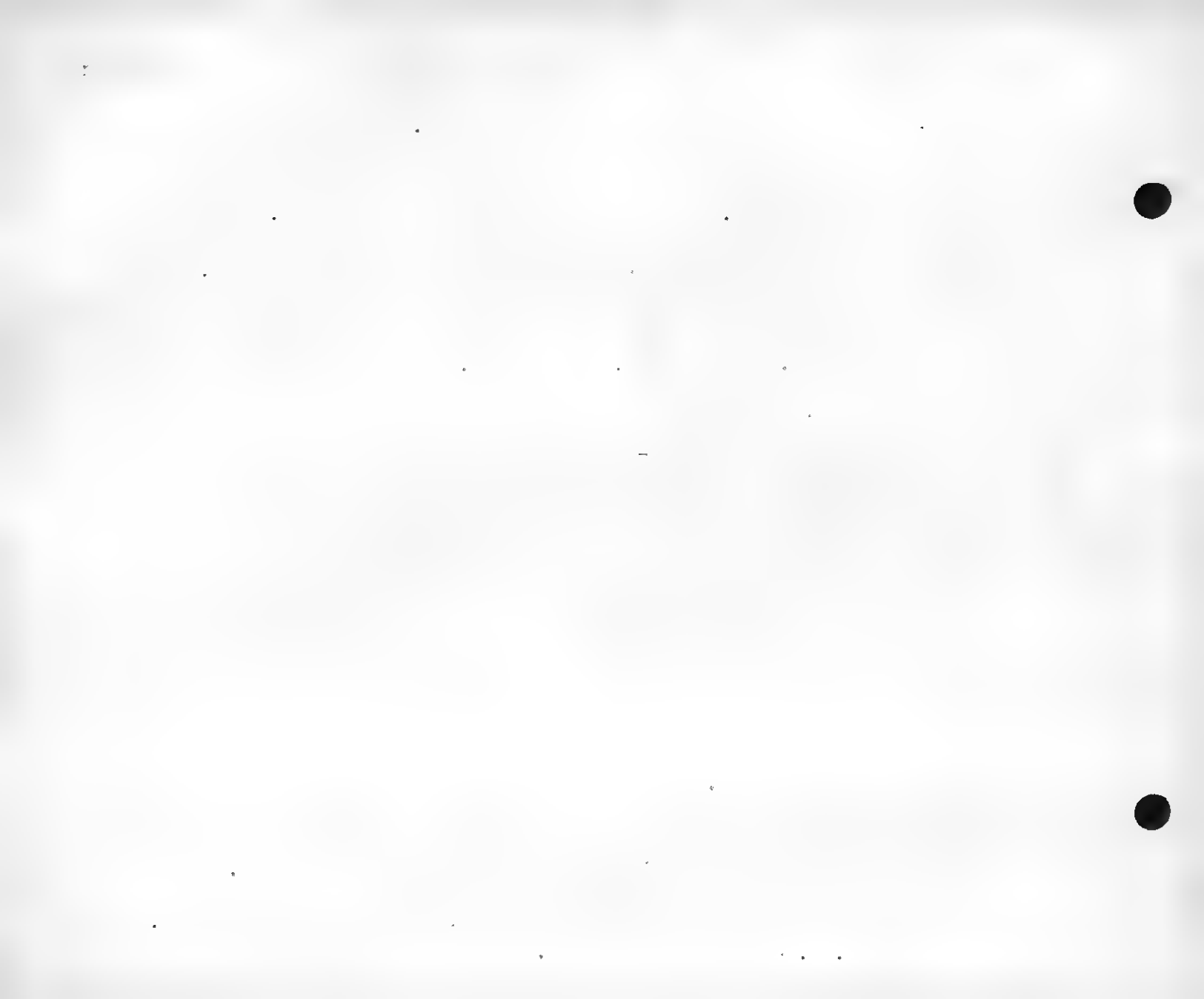
CERTIFICATE OF DEATH

15078

15082

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers - Pages 1 and 2 - and in any event, within 72 hours after death should be filed with the State Dept. of Health prior to burial, cremation, or removal.

1 PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE <u>Md.</u> b COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		c. LENGTH OF STAY IN 1b <u>Baltimore</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>204 Westshire Rd.</u>		d. STREET ADDRESS <u>204 Westshire Rd.</u>	
3 NAME OF DECEASED (Type or print) First Middle Last <u>William T. Ricktor</u>		4. DATE OF DEATH Month Day Year <u>Nov. 13, 1967</u>	
5 SEX <u>M</u>	6 COLOR OR RACE <u>wh</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 24, 1901</u>
9 AGE (in years last birthday) <u>66</u> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Engr.</u>	
11. BIRTHPLACE (County & State or foreign country) <u>Balto. Gas &amp; Elect. Co. Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Late - Wm. T. Ricktor</u>		14. MOTHER'S MAIDEN NAME <u>Late - Isadore</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO <u>212-05-6150</u>	
17. INFORMANT <u>Mrs. Helen Ricktor</u>		Address <u>204 Westshire Rd. - 21229</u>	
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I. DEATH CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardio-vascular Disease</u> DUE TO (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH <u>6 mos.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) <u>this hospital</u> attended the deceased from <u>Nov</u> , 19 <u>1950</u> <u>Nov.</u> , 19 <u>67</u> , that (I) <u>was</u> last saw the deceased alive on <u>Nov. 12</u> , 19 <u>67</u> , and that death occurred on <u>11/13/67</u> , from causes and on the date stated above			
22a. SIGNATURE <u>Leo Gaver</u>		22b. DATE SIGNED <u>11/13/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Leo Gaver</u>		22d. ADDRESS <u>1 Mallow Hill Rd.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>11/16/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cem.</u>	23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Md.</u>
24. FUNERAL DIRECTOR <u>Witzke F. D. - 4101 Edmondson Ave.</u>		25a. REC'D BY REGISTRAR DATE <u>NOV 15 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	



CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>6500 Crestwood Road</b>		d. STREET ADDRESS <b>6500 Crestwood Road</b>	
3 NAME OF DECEASED (Type or print) <b>Gertrude R. Rigger</b>		4 DATE OF DEATH Month <b>Nov.</b> Day <b>8,</b> Year <b>19 67</b>	
5 SEX <b>female</b>	6 COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>Feb. 23, 1905</b>
9 AGE (In years last birthday) <b>62</b> yrs		10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>	
10b KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (County & State, or foreign country) <b>Richmond, Virginia</b>	
12 CIT ZEN OF WHAT COUNTRY? <b>USA</b>		13 FATHER'S NAME <b>Lonnie Cottrell</b>	
14. MOTHER'S MAIDEN NAME <b>Martha Alley</b>		15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>	
16. SOCIAL SECURITY NO <b>- -</b>		17. INFORMANT <b>James C. Rigger</b> Address <b>6500 Crestwood Rd. #12</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Supra Cardiac</b> DUE TO <b>A C U D</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) INTERVAL BETWEEN ONSET AND DEATH <b>Approx. 1/2 hr.</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>Jan 15/67</b> , 19 to <b>Nov 8,</b> 1967 that (I) (we) last saw the deceased alive on <b>11/15/67</b> 19, and that death occurred at <b>5:22</b> M, from causes and on the date stated above			
22a. SIGNATURE <b>M. Pan 113 York Rd</b>		22b. DATE SIGNED <b>11/8/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>M. Pan 113 York Rd</b>		22d. ADDRESS <b>5820 York Rd</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>11/11/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Dulaney Valley Mem. Grds</b>	23d. LOCATION (City or Town) (County) (State) <b>Balto. County Md.</b>
24. BURIAL DIRECTOR <b>Mitchell-Wiedefeld Home</b>		25a. REC'D BY REGISTRAR <b>NOV 15 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers - Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.





## CERTIFICATE OF DEATH

15084

15081

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Balto.</u> #8 Gerard Ave., Towson, 4, Md. MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission). a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>		c. LENGTH OF STAY, N 16 <u>Life</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TOWSON.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>8 Gerard Ave</u>			d. STREET ADDRESS <u>8, Gerard Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>CLARENCE RINGGOLD</u> First <u>CHARLES RINGGOLD</u> Middle <u>CHARLES RINGGOLD</u> Last			4. DATE OF DEATH 11-11-67 Month Day Year		
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>DEC 6, 1899</u>	9. AGE (In years and days) <u>67</u> yrs	10. IF UNDER 1 YEAR Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) <u>HANDYMAN.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OUTDOOR</u>		11. BIRTHPLACE (County & State, or foreign country) <u>BALTO. MD.</u>	
13. FATHER'S NAME <u>CHARLES RINGGOLD</u>			12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO <u>220-01-0489</u>		
17. INFORMANT <u>Artha Ringgold</u>			18. Address <u>8, Gerard Ave. Towson</u>		
19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Carcinoma of stomach</u> DUE TO <u>with HEPATIC METASTASES</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>th</u>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>JAN</u> , 19 <u>62</u> , to <u>MAY 2</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>MAY 2</u> , 19 <u>67</u> , and that death occurred at <u>2:45</u> P.M. from causes and on the date stated above.					
22a. SIGNATURE <u>K. A. Manley</u>			22b. DATE SIGNED <u>11-11-67</u>		
22c. PHYSICIAN'S NAME (Type) <u>K. A. MANLEY, M.D.</u>			22d. ADDRESS <u>2045 York Road, Timonium, Md. 21093</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>11/16/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Pleasant Rest</u>		23d. LOCATION (City or Town) (County) (State) <u>Towson Balto. Co. Md.</u>
24. FUNERAL DIRECTOR <u>Ann L. Chatman</u>			25a. REC'D BY REGISTRAR <u>NOV 14 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>



15082

## CERTIFICATE OF DEATH

15085

1 PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>altimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Towson</i>		c. LENGTH OF STAY IN 1b <i>10 years for e- Salto. 21212</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>300 Murdock Road</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <i>ALICE R. ROBINSON</i>		4 DATE OF DEATH <i>Nov. 23 1967</i>	
5 SEX <i>Female</i>	6 COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <i>November 8, 1906</i>
9 AGE (n years last birthday) <i>61 yrs</i>		10 IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>own home</i>	
11. BIRTHPLACE (County & State, or foreign country) <i>Maryland</i>		12 CITIZEN OF WHAT COUNTRY <i>U.S.</i>	
13. FATHER'S NAME <i>Julie Richardson</i>		14. MOTHER'S MAIDEN NAME <i>Sarah Strawbridge</i>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>no one</i>		16 SOCIAL SECURITY NO	
17. INFORMANT <i>Geneva J. Robinson, 703 Dulaney Valley St.</i>		Address <i>Towson, Md.</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>G. S. C. v. disease</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>10/28</i> to <i>11/23</i> , 1967, that (I) (we) last saw the deceased alive on <i>11/16</i> 1967, and that death occurred at <i>7:45</i> M, from causes and on the date stated above			
22a. SIGNATURE <i>D. M. France</i>		22b. DATE SIGNED <i>11/23/67</i>	
22c. PHYSICIAN'S NAME (Type) <i>A. M. FRANCE</i>		22d. ADDRESS <i>PARRINGTON, Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>burial</i>	23b. DATE THEREOF <i>Nov. 25, 1967</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Bethel Presby. Cemetery</i>	23d. LOCATION (City or Town) (County) (State) <i>Andover, S. to. Co., Md.</i>
24. FUNERAL DIRECTOR ADDRESS <i>John Burns' Sons, Towson, Maryland</i>		25a. REC'D BY REGISTRAR <i>NOV 28 1967</i>	
		25b. REGISTRAR'S SIGNATURE <i>Charles V. [illegible]</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15083

## CERTIFICATE OF DEATH

15086

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>		c. LENGTH OF STAY IN MD <b>12093</b>		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Baltimore</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lutherville</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>St. Joseph Hospital</b>				e. STREET ADDRESS <b>1426 Burton Ave.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>William</b>		First <b>William</b>		Middle <b>H.</b>		Last <b>ROBINSON</b>		4. DATE OF DEATH Month <b>November</b>		Day <b>9</b>	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>12-22-1893</b>		9. AGE (In years last birthday) <b>73</b> yrs		IF UNDER 1 YEAR Months <b>9</b> Days <b>19</b> Hours <b>67</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>acoustician-ret.</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>S. &amp; P. Co.</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>James Robinson</b>						14. MOTHER'S MAIDEN NAME <b>Mary Fidler</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes</b>				16. SOCIAL SECURITY NO. <b>213-10-6269</b>		17. INFORMANT <b>Family records</b>				Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Left cerebral encephalomalacia</b> DUE TO (b) <b>thrombosis of left innominate artery</b> DUE TO (c) <b>severe atherosclerosis</b>										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that <b>20</b> (this hospital) attended the deceased from <b>11/5/</b> , 19 <b>67</b> , to <b>11/9/</b> , 19 <b>67</b> that <b>4</b> (we) last saw the deceased alive on <b>11/9/</b> , 19 <b>67</b> , and that death occurred at <b>12</b> M. from causes and on the date stated above.											
22a. SIGNATURE <b>Lawrence F. Misanik, M.D.</b>				22b. DATE SIGNED <b>November 9, 1967</b>				22c. PHYSICIAN'S NAME (Type) <b>Lawrence F. Misanik, M.D.</b>			
22d. ADDRESS <b>7620 York Rd., Towson, Md. 21204</b>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>				23b. DATE THEREOF <b>Nov. 13, 1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Prospect Hill Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Towson, Maryland</b>			
24. FUNERAL DIRECTOR <b>John Burns' Sons, Towson, Maryland</b>				25a. RECEIVED BY REGISTRAR <b>NOV 13 1967</b>				25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institut an Residence before admiss on) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>				
b. CITY OR TOWN (If outs de corporate limits, write RURAL and give nearest town) <u>Towson</u>			c. LENGTH OF STAY in lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore 21204</u>				
d. NAME OF HOSP TAL OR INSTITUT ON (If nat n hospital, give street address) <u>St. Joseph's Hospital</u>					d. STREET ADDRESS <u>217 Willow Avenue</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Graham</u> Middle <u>Rodemeyer</u> Last <u>Rodemeyer</u>					4. DATE OF DEATH Month <u>Nov.</u> Day <u>4</u> Year <u>19 67</u>				
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 19, 1893</u>		9. AGE (In years last birthday) yrs <u>74</u> IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPAT ON (Give kind of work done during most of working life, even if retired) <u>Retired Clerk</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Lever Bros.</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Rodemeyer</u>					14. MOTHER'S MAIDEN NAME <u>Margaret Cowens</u>				
15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of serv ce) <u>No</u>			16. SOCIAL SECURITY NO. <u>217-01-0494</u>		17. INFORMANT Address <u>Mrs. Mary E. Rodemeyer (Same)</u>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma Lung</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (the hospital) attended the deceased from <u>June 10</u> , 19 <u>67</u> , to <u>Nov 4</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Nov 4</u> , 19 <u>67</u> , and that death occurred at <u>4:30</u> P.M., from causes and on the date stated above.									
22a. SIGNATURE <u>Laurence C. Post</u>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>11/6/67</u>		
22c. PHYSICIAN'S NAME (Type) <u>LAURENCE C. POST</u>					22d. ADDRESS <u>6805 York Rd - Baltimore 21212 Md</u>				
23a. BURIAL, CREMATON, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>11/7/67.</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cemetery</u>			23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Md.</u>		
24. FUNERAL DIRECTOR <u>Leonard J. Ruck, Inc Baltimore, Md.</u>					25a. REC'D BY REGISTRAR DATE <u>NOV 6</u> 19 <u>67</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		





CERTIFICATE OF DEATH

15 08

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <b>BALTO.</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MD.</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE TOWSON</b>		c. LENGTH OF STAY IN 1b <b>BALTIMORE</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>GREATER BALTIMORE MED. CENTER</b>		d. STREET ADDRESS <b>402 E. Coldspring Lane</b>	
3 NAME OF DECEASED (Type or print) First <b>PETER</b> Middle <b>S.</b> Last <b>ROSE</b>		4 DATE OF DEATH Month <b>NOVEMBER</b> Day <b>20</b> Year <b>1967</b>	
5 SEX <b>MALE</b>	6 COLOR OR RACE <b>CAUC.</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>8-15-1889</b>
9 AGE (In years last birthday) <b>78</b> yrs		IF UNDER 1 YEAR Months Days Hours Min.	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED</b>		10b KIND OF BUSINESS OR INDUSTRY <b>RETIRED</b>	
11 BIRTHPLACE (County & State, or foreign country) <b>GREECE</b>		12 CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13 FATHER'S NAME <b>STAVROS STEVE ROSE (ROUSOUNIS)</b>		14 MOTHER'S MAIDEN NAME <b>UNKNOWN MARY ?</b>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16 SOCIAL SECURITY NO <b>218-28-2070</b>	
17 INFORMANT <b>PATIENT'S CHART</b>		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiorespiratory failure</b> DUE TO (b) <b>Bilateral Subdural hematoma</b> DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		INTERVAL BETWEEN ONSET AND DEATH <b>27 days</b>	
PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d INJURY OCCURRED While <input type="checkbox"/> Nat While <input type="checkbox"/> at work at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>10-24-1967</b> to <b>11-20-1967</b> , that (I) (we) last saw the deceased alive on <b>11-20-1967</b> , and that death occurred at <b>7-40 PM</b> , from causes and on the date stated above			
22a SIGNATURE <b>Dipak Kumar Mallik</b>		22b DATE SIGNED <b>11/21/67</b>	
22c PHYSICIAN'S NAME (Type) <b>DIPAK KUMAR MALLIK</b>		22d ADDRESS <b>Greater Baltimore Medical Center</b>	
23a BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b DATE THEREOF <b>11-24-67</b>	23c NAME OF CEMETERY OR CREMATORY <b>Greek Orthodox</b>	23d LOCATION (City or Town) (County) (State) <b>Balto. Md.</b>
24 FUNERAL DIRECTOR <b>H.W. Jenkins &amp; Sons Co. 4905 York Rd.</b>		25a REC'D BY REGISTRAR DATE <b>NOV 21 1967</b>	
		25b REGISTRAR'S SIGNATURE <b>Charles J. Jones</b>	



**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

1. PLACE OF DEATH  
a. COUNTY Baltimore  
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)  
c. LENGTH OF STAY in 1b  
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)  
2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)  
a. STATE Maryland b. COUNTY Baltimore  
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)  
d. STREET ADDRESS  
3. NAME OF DECEASED (Type or print)  
4. DATE OF DEATH  
5. SEX  
6. COLOR OR RACE  
7. MARRIED ☒ NEVER MARRIED ☐  
8. DATE OF BIRTH  
9. AGE (in years last birthday)  
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  
11. BIRTHPLACE (County & State, or foreign country)  
12. CITIZEN OF WHAT COUNTRY  
13. FATHER'S NAME  
14. MOTHER'S MAIDEN NAME  
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)  
16. SOCIAL SECURITY NO.  
17. INFORMANT  
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))  
PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a)  
CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (b), (c)  
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  
19. WAS AUTOPSY PERFORMED?  
YES ☐ NO ☐  
20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)  
20c. TIME OF INJURY Month, Day, Year  
20d. INJURY OCCURRED While ☐ Not While ☐  
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  
20f. (City or town) (County) (State)  
21. I certify that (I) (this hospital) attended the deceased from 10/30 to 11/3, 1967, that (I) (we) last saw the deceased alive 11/3, 1967, and that death occurred at 11/3, 1967, from the causes and on the date stated above  
22a. SIGNATURE  
22b. DATE SIGNED  
22c. PHYSICIAN'S NAME (Type)  
22d. ADDRESS  
23a. BURIAL, CREMATION, REMOVAL (Specify)  
23b. DATE THEREOF  
23c. NAME OF CEMETERY OR CREMATORY  
23d. LOCATION (City, town or county) (State)  
24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS  
25a. REC'D BY REGISTRAR  
25b. REGISTRAR'S SIGNATURE

**HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician.

**FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after burial.

VR AIS (41)  
15M 7.61



15087

## CERTIFICATE OF DEATH

1590

1 PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
c. LENGTH OF STAY IN 1b <b>1 Yr</b>		<b>Baltimore</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>33 Dowling Circle</b>		d. STREET ADDRESS <b>33 Dowling Circle</b>	
3 NAME OF DECEASED (Type or print) <b>Mildred Elizabeth Ruby</b>		4 DATE OF DEATH <b>11-3-67</b>	
5 SEX <b>Female</b>	6 COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>8-15-17</b>
9 AGE (In years last birthday) <b>50</b> yrs		10 UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Balto. Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Harry A. Wagner</b>		14. MOTHER'S MAIDEN NAME <b>Mary A. Rosenberger</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) <b>No</b>		16 SOCIAL SECURITY NO <b>212 09 9476</b>	
17. INFORMANT <b>Charles E. Wagner</b>		Address <b>939 Beaver Bank Circle</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cancer of brain</u> DUE TO (b) <u>(glioblastoma multiforme)</u> DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>11/5</u> , 19 <u>67</u> , to <u>11/3</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>11/3</u> , 19 <u>67</u> , and that death occurred at <u>2:00</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>W. M. Meredith Smith</u>		22b. DATE SIGNED <u>11/4/67</u>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. W. Meredith Smith</b>		22d. ADDRESS <b>6305 The Alemda, Baltimore, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL <b>Burial</b>	23b. DATE THEREOF <b>11-6-67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Moreland Mem. Park Cem.</b>	23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Maryland</b>
24. FUNERAL DIRECTOR <b>Wm. E. Johnson, 8521 Loch Raven Blvd. 21204</b>		25a. REC'D BY REGISTRAR <b>NOV 8 1967</b>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



CERTIFICATE OF DEATH

15088 15081

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a COUNTY <b>Baltimore</b> b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b> c LENGTH OF STAY IN 1b <b>Baltimore</b>		2 USUAL RESIDENCE (Where deceased lived, f institution Residence before adm ssion) a. STATE <b>Md., 21213</b> b COUNTY <b>✓</b>	
3 NAME OF DECEASED (Type or print) <b>ELIZABETH RUNSHEIMER</b>		4. DATE OF DEATH Month <b>Nov.</b> Day <b>13</b> Year <b>19 67</b>	
5 SEX <b>female</b>	6 COLOR OR RACE <b>white</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>9/12/82</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, given if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>at home</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore, Md.</b>		12 CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>George Runsheimer</b>		14. MOTHER'S MAIDEN NAME <b>Anna Schmidt</b>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO	
17 INFORMANT <b>Marie Gunzelman, dght, above</b>		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: <b>445X</b> IMMEDIATE CAUSE (a) <b>Pneumonia</b> DUE TO (b) <b>Fracture, surgical neck of humerus</b> DUE TO (c) <b>1 week</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Generalized arterio-sclerosis</b>		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <b>fall out of bed</b>	
20c. TIME OF INJURY Month, Day, Year <b>3 p.m. ✓ 11-6 1967</b>		20d. INJURY OCCURRED While <input type="checkbox"/> hot While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>nursing home</b>		20f. (City or town) (County) (State) <b>Catonsville Balto. Md.</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>Oct., 1964</b> , to <b>Nov. 13, 1967</b> , that (I) (we) last saw the deceased alive on <b>11-11 1967</b> , and that death occurred at <b>232AM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>J. Duer Moores</b>		22b. DATE SIGNED <b>11-13-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. J. Duer Moores</b>		22d. ADDRESS <b>3105 Belair Road</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11/15/67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer Cem.</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Md.</b>	
24. FUNERAL DIRECTOR <b>Schimunek Funeral Home, Inc.</b>		25a. REC'D BY REGISTRAR <b>DATA 11 1 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>OFFICIAL Under</b>			





15089

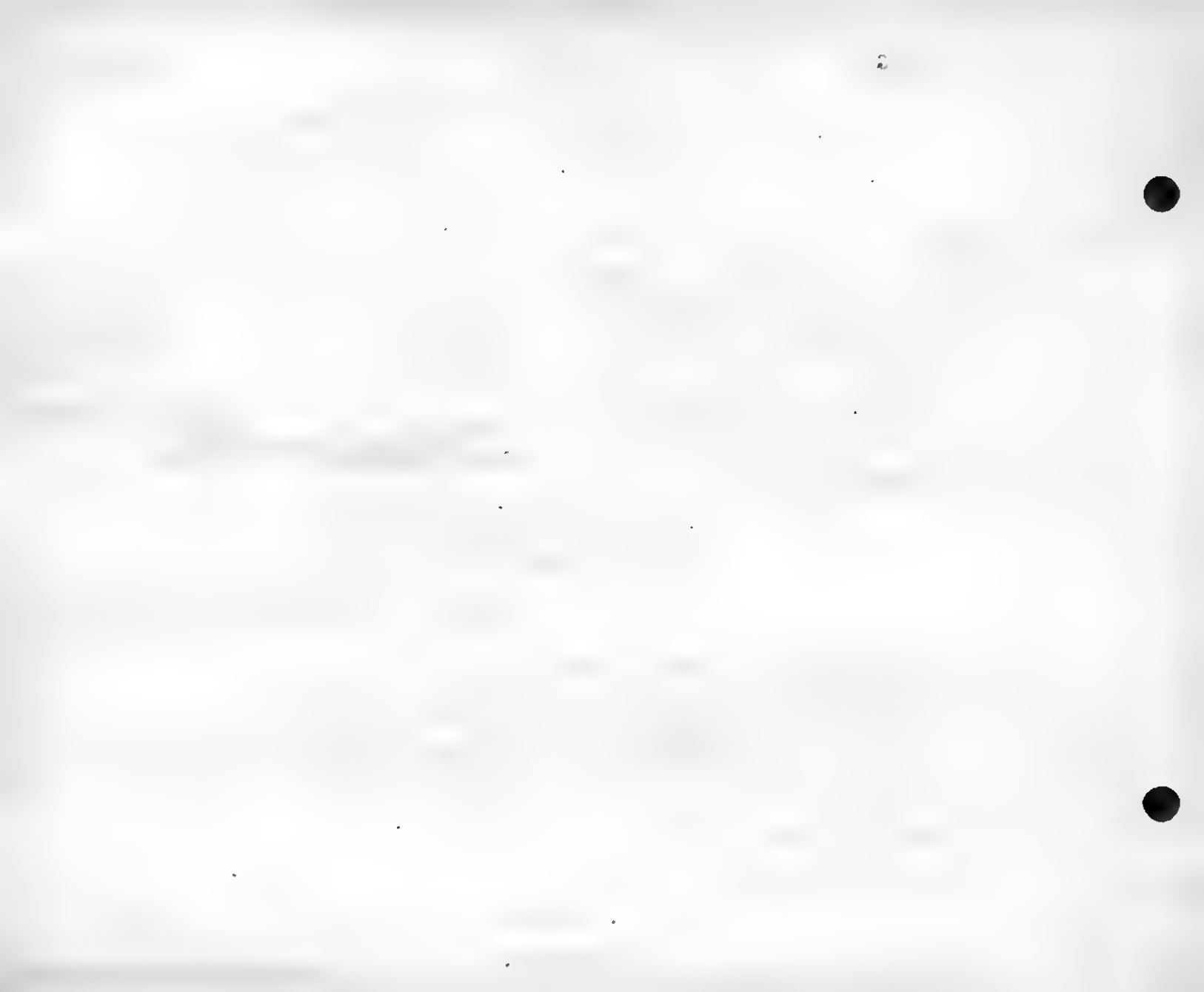
CERTIFICATE OF DEATH

1532

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. LENGTH OF STAY IN <u>11 mos. 20 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Forest Haven Nursing Home</u>		d. STREET ADDRESS <u>1223 S. CLINTON ST</u>	
3 NAME OF DECEASED (Type or print) First Middle Last <u>Mary Ann Rutkowski</u>		4 DATE OF DEATH Month <u>11</u> Day <u>25</u> Year <u>1967</u>	
5 SEX <u>Female</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-9-84</u>
9 AGE (in years last birthday) <u>83</u> yrs		IF UNDER 1 YEAR Months <u>11</u> Days <u>25</u> Hours <u>19</u> Min <u>67</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Poland</u>		12. CITIZEN OF WHAT COUNTRY? <u>Poland</u>	
13. FATHER'S NAME <u>Ignatius Gradzki</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO <u>1123 S. CLINTON</u>	
17. INFORMANT <u>Josephine KEBERSKI</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))	
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>A 99 year old female</u>		INTERVAL BETWEEN ONSET AND DEATH	
(b) <u>11 mos. 20 days</u>			
(c) <u>11 mos. 20 days</u>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS A TOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>11/1</u> , 19 <u>65</u> , to <u>11/26</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>11/26</u> , 19 <u>67</u> , and that death occurred at <u>4:00</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>John W. Shaw</u>		22b. DATE SIGNED <u>11/27/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>John W. Shaw</u>		22d. ADDRESS <u>Sec. Emergency Room Baltimore</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>11-29-67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>St. Stanislaus</u>		23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Maryland</u>	
24. FUNERAL DIRECTOR <u>Marie Fialkowski</u>		25a. REC'D BY REGISTRAR <u>NOV 29 1967</u>	
ADDRESS <u>1000 S. Kenwood Ave. Balto</u>		25b. REGISTRAR'S SIGNATURE <u>John W. Shaw</u>	



## CERTIFICATE OF DEATH

15098

15093

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (When deceased lived in institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Balto.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
c. LENGTH OF STAY IN lb <u>2 1/2 hr</u>		d. STREET ADDRESS <u>6417 Lehnart St</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Baltimore County</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>THERMA</u> Middle <u>B.</u> Last <u>ST. CLAIR</u>		4. DATE OF DEATH Month <u>November</u> Day <u>7</u> Year <u>19 67</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/26/05</u>
9. AGE (In years last birthday) <u>62</u> yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>H. W.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>Airey ?</u>		14. MOTHER'S MAIDEN NAME <u>?</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u> <u>NO</u>		16. SOCIAL SECURITY NO. <u>217-12-7837</u>	
17. INFORMANT <u>Mr. Charles St Clair Sr. Same as #2</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>4201</u> IMMEDIATE CAUSE (a) <u>Severe Diffuse Pulmonary Edema</u> DUE TO (b) <u>Myocardial Insufficiency</u> DUE TO (c) <u>Recent Myocardial Infarct</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			
INTERVAL BETWEEN ONSET AND DEATH <u>Hours</u> <u>Hours</u> <u>2-3 weeks</u>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that ( ) (th's hospital) attended the deceased from <u>Nov. 7</u> , 19 <u>67</u> , to <u>Nov. 7</u> , 19 <u>67</u> , and that death occurred at <u>9:30 P.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Kenturanza</u>		22b. DATE SIGNED <u>11-7-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>KENTURANZA</u>		22d. ADDRESS <u>Baltimore County General Hosp</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>11/11/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn</u>	23d. LOCATION (City or Town) (County) (State) <u>Baltimore Md.</u>
24. FUNERAL DIRECTOR <u>J. T. Stansbury</u>		25a. REC'D BY REGISTRAR <u>NOV 10 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15091

## CERTIFICATE OF DEATH

15094

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson 4</b> c. LENGTH OF STAY IN 1b <b>18 Yrs</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>St. Joseph Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>1805 Briarcliffe Road</b> d. STREET ADDRESS <b>Baltimore #21234</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>CHRISTINE (none) SANDS</b>		4. DATE OF DEATH Month Day Year <b>November 11, 1967</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7-24-1898</b>
9. AGE (In years last birthday) <b>69 yrs</b>		10. USUAL OCC. PAT. ON (Give kind of work done during most of working life, even if retired) <b>homemaker</b>	
10b. K. ND. OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Pennsylvania</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Benjamin Oliver</b>	
14. MOTHER'S MAIDEN NAME <b>Bessie Mathews</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>	
16. SOCIAL SECURITY NO. <b>183 22 7664</b>		17. INFORMANT <b>Violet S. Malesh</b> Address <b>21234</b> <b>1805 Briarcliffe Rd.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral aneurysm</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (this hospital) attended the deceased from <b>September 19, 1967</b> , to <b>November 11, 1967</b> , that (we) lost saw the deceased alive on <b>November 11, 1967</b> , and that death occurred at <b>10:30M</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>Joel Tolentino, M.D.</b>		22b. DATE SIGNED <b>November 11, 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>Joel Tolentino, M. D.</b>		22d. ADDRESS <b>7620 York Road, Towson 4, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>11-14-67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Rarkwood Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Balto. Balto. Md.</b>
24. FUNERAL DIRECTOR <b>Wm. E. Johnson</b> ADDRESS <b>8521 Loch Raven Blvd. 21204</b>		25a. REC'D BY REGISTRAR DATE <b>NOV 15 1967</b>	25b. REGISTRAR'S SIGNATURE <b>John J. Judge</b>



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15092

## CERTIFICATE OF DEATH

15095

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1 PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. LENGTH OF STAY in lb <u>2 1/2 yrs.</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Spring Grove State Hospital</u>		d. STREET ADDRESS <u>6005 Gwynn Oak Ave.</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3 NAME OF DECEASED (Type or print) First <u>Roulston</u> Middle <u>E.</u> Last <u>Schaeffer</u>		4. DATE OF DEATH Month <u>11</u> Day <u>19</u> Year <u>1967</u>	
5 SEX <u>M</u>	6 COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>JUNE 23 1904</u>
9 AGE (In years last birthday) <u>63</u> yrs		10 UNDER 1 YEAR Months <u>1</u> Days <u>19</u> Hours <u>19</u> Min <u>63</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Self-Employed</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>GAS STATION</u>	
11 BIRTHPLACE (County & State, or foreign country) <u>BALTIMORE</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13 FATHER'S NAME <u>William D. Schaeffer</u>		14 MOTHER'S MAIDEN NAME <u>EVANS</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16 SOCIAL SECURITY NO <u>213-05-4229</u>	
17 INFORMANT <u>chart-Mildred R Schaeffer-Same</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>congestive heart failure</u> <u>475X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) <u>pneumonia</u> DUE TO (c) <u>general debility</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>1 wk</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>treated</u> <u>chronic brain syndrome, poss. tertiary syphilis</u>		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>11/19</u> , 19 <u>67</u> , to <u>11/19</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>11/19</u> , 19 <u>67</u> , and that death occurred at <u>6:55</u> A.M., from causes and on the date stated above.			
22a. SIGNATURE <u>Ann Louise Silver</u>		22b. DATE SIGNED <u>11/19/67</u>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>11-22-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Md.</u>
24. FUNERAL DIRECTOR <u>Elsworth Armacost-4600 Liberty Heights Ave -</u>		25a. REC'D BY REGISTRAR <u>NOV 22 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>James J. Jones</u>	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper - pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

# CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Glenarm Md.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Glenarm</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Box 309 Manor Rd</u>		d. STREET ADDRESS <u>Box 309 Manor Rd</u>	
3. NAME OF DECEASED (Type or print) <u>William H Schafer</u>		4. DATE OF DEATH Month <u>11</u> Day <u>18</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 12, 1901</u>
9. AGE (In years last birthday) <u>66</u> yrs		10. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Maryland Casualty</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Albert Schafer</u>		14. MOTHER'S MAIDEN NAME <u>Mina Thomas</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO	
17. INFORMANT <u>Mrs Carolun Schafer</u>		Address <u>Same</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized Carcinomatosis</u> DUE TO <u>Rectal adenocarcinoma</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>April 19, 1967</u> , to <u>November 18, 1967</u> , that (I) (we) lost now the deceased alive on <u>November 16, 1967</u> , and that death occurred at <u>5:30</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Henry McCorkle</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>Dr Henry McCorkle</u>		22d. ADDRESS <u>Phoenix Md 21131</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>11/22/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St John's</u>	23d. LOCATION (City or Town) (County) (State) <u>Hudes Baltimore Md</u>
24. FUNERAL DIRECTOR <u>Leonard J Ruck Inc 5305 Harford Rd</u>		25a. REC'D BY REGISTRAR <u>21 NOV 1967</u> 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15094

15097

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <b>Catonsville</b> c. LENGTH OF STAY in b <b>1 day</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>921 Presswood St.</b>		2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>---</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>2201 W. Pratt St.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Arthur George Schilling</b>		4. DATE OF DEATH Month Day Year <b>November 23 19 67</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> W. DOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 22, 1911</b> 9. AGE (n years lost birthday) yrs <b>56</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>sCity Govt.</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
13. FATHER'S NAME <b>Henry Schilling</b>		14. MOTHER'S MAIDEN NAME <b>Amelia Trump</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give year or dates of service) <b>Yes World War II</b>		16. SOCIAL SECURITY NO <b>219-01-6870</b>	
17. INFORMANT <b>Olga Schilling</b>		Address <b>733 S. Woodington Rd.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. <b>4221 IMMEDIATE CAUSE (a) Cardio Vascular Disease</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WA. AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>James N. Frederick</i> EXAMINER'S NAME (Type) <b>James N. Frederick, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <b>11/24/67</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>11/27/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>	23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Maryland</b>
24. FUNERAL DIRECTOR <b>Geo. L. Schwab Funeral Home</b> <b>Francis W. Miller 2101 Frederick Avenue</b>		25a. REC'D BY REGISTRAR DATE <b>NOV 27 1967</b> 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (1)  
25M 1/67

15095

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
Items #2 & 9 Filed 12/14/67 ph

15098

CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> c. LENGTH OF STAY IN lb <u>2</u>		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>—</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>1232 Kahler Ave.</u>		d. STREET ADDRESS <u>302 N. Athol Ave.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Albert E. Schlier</u>		4. DATE OF DEATH Month Day Year <u>Nov. 23 19 67</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>Wn</u>	7. <del>MARRIED</del> <input checked="" type="checkbox"/> <del>NEVER MARRIED</del> <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> <del>DIVORCED</del> <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>12/12/1909</u> 9. AGE (In years last birthday) <u>84</u> yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William</u>		14. MOTHER'S MAIDEN NAME <u>Mosuri</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Mrs. Ellen Schaeffer</u> <u>1232 Kahler Ave.</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4201</u> DUE TO <u>Cardiac Arrest</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>General and Coronary Arteriosclerosis</u> (c) <u>with heart failure</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1B)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (1) (this hospital) attended the deceased from <u>11-22</u> , 19 <u>67</u> , to <u>11-23</u> , 19 <u>67</u> , that (1) (we) last saw the deceased alive on <u>11-22</u> , 19 <u>67</u> , and that death occurred at <u>—</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>L. John Geldrich</u> M.D.		22b. DATE SIGNED <u>11/25/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>John Geldrich</u>		22d. ADDRESS <u>8019 Philadelphia Rd.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>11/27/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Moreland Mem. Pk. Cem.</u>	23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Md.</u>
24. FUNERAL DIRECTOR <u>Witzke F. D. - 4101 Edmondson Ave.</u>		25a. REC'D BY REGISTRAR DATE <u>NOV 27 1967</u>	25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15099

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>_____</b> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>		c. LENGTH OF STAY IN TB _____	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>St. Joseph Hospital</b>		d. STREET ADDRESS <b>4012 Chesley Ave.</b>	
3. NAME OF DECEASED (Type or print) <b>MARY B. SCHUSSELE</b>		4. DATE OF DEATH Month <b>NOVEMBER</b> Day <b>3</b> Year <b>1967</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 28, 1913</b>
9. AGE (in years last birthday) <b>54</b> yrs		10. IF UNDER 1 YEAR Months _____ Days _____ IF UNDER 24 HRS Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Dental technician</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Frank J. Schusselle</b>	
14. MOTHER'S MAIDEN NAME <b>Mary B. Clifford</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes give war or dates of service)	
16. SOCIAL SECURITY NO. <b>212-18-5180</b>		17. INFORMANT <b>Francis J. Schusselle</b> Address <b>Balto. Md. 28 1012 Markworth Rd.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH CAUSED BY: <b>163X</b> IMMEDIATE CAUSE (a) <b>Massive empyema, right pleural cavity</b> DUE TO (b) <b>Right pneumonectomy for carcinoma of the right lung</b> DUE TO (c) _____			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Esophagitis</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year <b>Sept. 9, 1967</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <b>1</b> (this hospital) attended the deceased from <b>Sept. 9, 1967</b> , to <b>Nov. 3, 1967</b> , that <b>1</b> (we) last saw the deceased alive on <b>Nov. 3, 1967</b> , and that death occurred at <b>10:15 PM</b> from causes and on the date stated above.			
22a. SIGNATURE <b>Samuel Lee</b>		22b. DATE SIGNED <b>11-4-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Samuel Lee, M.D.</b>		22d. ADDRESS <b>6720 York Road, Towson, Md. 21204</b>	
23a. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>11/3/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Parkwood Cem.</b>	23d. LOCATION (City or Town) (County) (State) <b>Balto. Md.</b>
24. FUNERAL DIRECTOR <b>Leonard J. Ruck Inc. Balto. Md.</b>		25a. REC'D BY REGISTRAR <b>DATE NOV 6 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>James Judge</b>			





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15097

15100

1 PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institut on Residence before admssion) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CATONSVILLE</b>		c. LENGTH OF STAY IN 1b <b>9 weeks</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Summit Nursing Home</b>		d. STREET ADDRESS <b>7251 FAIRBROOK RD</b>	
3 NAME OF DECEASED (Type or print) <b>Ray Service</b>		4. DATE OF DEATH Month <b>November</b> Day <b>8</b> Year <b>1967</b>	
5 SEX <b>M</b>	6 COLOR OR RACE <b>Caucasian</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb 29 1888</b>
9. AGE (In years last birthday) <b>79 yrs</b>		10. BIRTHPLACE (County & State, or foreign country) <b>PA.</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>PA.</b>		12 CIT ZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JAMES C. SERVICE</b>		14. MOTHER'S MAIDEN NAME <b>Eliza Siddons</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <b>207147290</b>	
17. INFORMANT <b>CHART</b>		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>1) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE, LEFT BUNDLE BRANCH BLOCK</b> DUE TO (b) <b>2) CEREBROVASCULAR ACCIDENT</b> DUE TO (c) <b>3) CORONARY ARTERY DISEASE CHRONIC CONGESTIVE HEART FAILURE</b>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>1) HYPERTENSION</b>			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. <b>11</b> p.m. <b>19</b>	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>PHILPA PA.</b>	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>9/16</b> , 19 <b>67</b> , to <b>11/8</b> , 19 <b>67</b> that (I) (we) lost saw the deceased alive on <b>11/8</b> , 19 <b>67</b> , and that death occurred at <b>10:30 PM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>E. Kasaitis, M.D.</b>		22b. DATE SIGNED <b>11/8/1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>E. KASAITIS, M.D.</b>		22d. ADDRESS <b>1801 FREDERICK RD + 21228</b>	
23a BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b DATE THEREOF <b>11/13/67</b>	23c NAME OF CEMETERY OR CREMATORY <b>W. LAUREL HILL</b>	23d LOCATION (City or Town) (County) (State) <b>PHILPA PA.</b>
24. FUNERAL DIRECTOR <b>F. S. MALNABIS 21228</b>		25a REC'D BY REGISTRAR DATE <b>NOV 13 1967</b>	
		25b REGISTRAR'S SIGNATURE <b>R Charles Judge</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR #15 (1)  
20M 1/65

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Hude</i>		c. LENGTH OF STAY IN 1b <i>Hude</i>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Hude Road</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <i>Robert Leonard Sewell</i>		4. DATE OF DEATH Month Day Year <i>November 22, 1967</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Oct. 17, 1892</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>rocer - retail</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Self employed</i>	9. AGE (In years last birthday) <i>75</i> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
11. BIRTHPLACE (County & State, or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>William Sewell</i>		14. MOTHER'S MAIDEN NAME <i>Mary Pennington</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <i>705-10-8969</i>	
17. INFORMANT <i>Family records</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial infarct</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Cerebral thrombosis</i> (c) <i>Arteriosclerotic P.V. disease</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Diabetes Mellitus</i>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <i>Oct</i> , 19 <i>66</i> , to <i>Nov 22</i> , 19 <i>67</i> , that (I) ( <del>we</del> ) last saw the deceased alive on <i>Nov 22</i> , 19 <i>67</i> , and that death occurred at <i>4:15</i> P.M. from the causes and on the date stated above.			
22a. SIGNATURE <i>Cesar S. Vasquez, M.D.</i>		22b. DATE SIGNED <i>11-24-67</i>	
22c. PHYSICIAN'S NAME (Type) <i>CESAR S. VASQUEZ, M.D.</i>		22d. ADDRESS <i>BELAIR, MD</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>burial</i>		23b. DATE THEREOF <i>Nov. 25, 1967</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Fallston Methodist Cem</i>		23d. LOCATION (City, town or county) (State) <i>Fallston, Calverton, Md.</i>	
24. FUNERAL DIRECTOR <i>John Burns Sons, Towson, Maryland</i>		25a. REC'D BY REGISTRAR <i>Charles Judge</i>	
25b. REGISTRAR'S SIGNATURE		DATE <i>NOV 27 1967</i>	



CERTIFICATE OF DEATH

15102

1. PLACE OF DEATH a. COUNTY <u>BALTO COUNTY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>BALTO</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>1111</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>SHADY NOOK COIN HOME</u>		d. STREET ADDRESS <u>616 COLEMAN RD</u>	
3. NAME OF DECEASED (Type or print) <u>BLANCHE B SHAWER</u>		4. DATE OF DEATH Month <u>NOV</u> Day <u>25</u> Year <u>1967</u>	
5. SEX <u>MF</u>	6. COLOR OR RACE <u>N</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/11/21</u>
9. AGE (In years last b. day) <u>46</u> yrs		10. IF UNDER 1 YEAR Months <u>11</u> Days <u>14</u> Hours <u>11</u> Min <u>11</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>BALTO MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>JOHN T. FREELAND</u>		14. MOTHER'S MAIDEN NAME <u>EMILY JANE DWYER</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>N/A</u>		16. SOCIAL SECURITY NO <u>212-53-3626</u>	
17. INFORMANT <u>JOHN T. RAD</u>		Address <u>1200 CEDAR CIRCLE CT</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Repermeation</u> + + + + + DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized Atherosclerosis</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>3 wks</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Diabetes Mellitus</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>9-7-1962</u> to <u>11-25-1967</u> that (I) (We) last saw the deceased alive on <u>11-24-1967</u> , and that death occurred at <u>5:30 P.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Wilmer K. Gallagher</u>		22b. DATE SIGNED <u>11/27/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Wilmer K. Gallagher</u>		22d. ADDRESS <u>6209 Frederick Ave. Balt, 21225 Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>11/28/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>WOODLAWN CEM.</u>	23d. LOCATION (City or Town) (County) (State) <u>BALTO MD</u>
24. FUNERAL DIRECTOR <u>WEBER FUNERAL HOME 5311</u>		25a. REC'D BY REGISTRAR DATE <u>NOV 27 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>John C. Jones</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15666

15.00

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Randallstown</u>		c. LENGTH OF STAY IN 1b <u>Reisterstown, Md.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Chapel Hill Nursing Home, Randallstown, Md.</u>		d. STREET ADDRESS <u>Deer Park Road</u>	
3 NAME OF DECEASED (Type or print) <u>Annie Elizabeth Shipley</u>		4. DATE OF DEATH Month <u>November</u> Day <u>30</u> Year <u>1967</u>	
5 SEX <u>Female</u>	6 COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 2, 1874</u> 9 AGE (In years last birthday) <u>93</u> yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	11. BIRTHPLACE (County, State, or foreign country) <u>Baltimore, Md.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Amos Taylor</u>	
14. MOTHER'S MAIDEN NAME <u>Emma Akehurst</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>	
16 SOCIAL SECURITY NO <u>215-48-0637</u>		17 INFORMANT <u>Mrs. Esther S. Callahan, 7 Hawthorne Ave., Pikesville, Md.</u>	
18 CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c).) PART I. DEATH CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocarditis - Decompen</u> DUE TO (b) <u>Hypertension cardiovascular</u> DUE TO (c) <u>disease</u>			INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>✓</u>			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part I at item 18) <u>✓</u>	
20c TIME OF INJURY Month, Day, Year Hour a.m. <u>✓</u> 19 <u>✓</u> p.m. <u>✓</u>	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>✓</u>	20f (City or town) (County) (State) <u>✓</u>
21. I certify that (I) (this hospital) attended the deceased from <u>1-1-1940</u> to <u>11-30-1967</u> , that (I) (we) last saw the deceased alive on <u>11-30-1967</u> , and that death occurred at <u>5:30</u> M, from causes and on the date stated above.			
22a SIGNATURE <u>James P. Saffell</u>		22b DATE SIGNED <u>12-2-67</u>	
22c PHYSICIAN'S NAME (Type) <u>James P. Saffell</u>		22d ADDRESS <u>Reisterstown, Md.</u>	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b DATE THEREOF <u>Dec. 2, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Reisterstown Meth. Cemetery</u>	23d LOCATION (City or Town) (County) (State) <u>Reisterstown, Baltio. Md.</u>
24 FUNERAL DIRECTOR <u>Frank H. Stowell</u>		25a REC'D BY REGISTRAR <u>Charles Judge</u>	25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1 (M)

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15101

15103

1 PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>_____</b> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>		c. LENGTH OF STAY IN 1b <b>59 Days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Veterans Administration Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First <b>FREDERICK</b> Middle <b>ALBERT</b> Last <b>SHIPLEY</b>		4. DATE OF DEATH Month <b>NOVEMBER</b> Day <b>4</b> Year <b>19 67</b>	
5 SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4/24/99</b>
9 AGE (In years lost birthday) yrs <b>68</b>		10. IF UNDER 1 YEAR Months <b>_____</b> Days <b>_____</b>	11. IF UNDER 24 HRS Hours <b>_____</b> Min <b>_____</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Printer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Printing</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S. A.</b>	
13. FATHER'S NAME <b>J. Michael Shipley</b>		14. MOTHER'S MAIDEN NAME <b>A. Mary Meyers</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes WWII</b>		16. SOCIAL SECURITY NO <b>215-05-11-14</b>	
17. INFORMANT <b>Clin. Rec. VAH, Fort Howard, Maryland</b>		Address <b>_____</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>METASTATIC CARCINOMA OF THE BRAIN</b> DUE TO (b) <b>LESION OF RIGHT LUNG</b> DUE TO (c) <b>_____</b>			
19. INTERVAL BETWEEN ONSET AND DEATH <b>UNKNOWN</b>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>1700</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b>_____</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>Sept. 6</b> , 19 <b>67</b> , to <b>Nov. 4</b> , 19 <b>67</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>Nov. 4</b> , 19 <b>67</b> , and that death occurred at <b>11:45AM</b> causes and on the date stated above.			
22a. SIGNATURE <i>Conrado L. Mancao, M.D.</i>		22b. DATE SIGNED <b>11/4/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>CONRADO L MANCAO, M.D.</b>		22d. ADDRESS <b>VA HOSPITAL, FORT HOWARD, MARYLAND</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>11-8-1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Maryland</b>
24. FUNERAL DIRECTOR <b>Howard M. Hubbard Fun. Home</b>		25a. REC'D BY REGISTRAR <b>4107 Wilkens Ave Baltimore, Md.</b>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Balto</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>		c. LENGTH OF STAY IN 1b <b>Parkville</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Armcast Nursing Home</b>		d. STREET ADDRESS <b>2800 Joppa road</b>	
3 NAME OF DECEASED (Type or print) <b>ANTHONY R SIMMEL</b>		4. DATE OF DEATH Month <b>November</b> Day <b>6</b> Year <b>19 67</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 4 1886</b>
9 AGE (In years last birthday) <b>81</b> yrs		10 UNDER 1 YEAR Months <b>11</b> Days <b>7</b> Hours <b>1</b> Min <b>03</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Owner</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Tavern</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CIT ZEN OF WHAT COUNTRY? <b>USA</b>	
13 FATHER'S NAME <b>John J. Simmel</b>		14 MOTHER'S MAIDEN NAME <b>Kate Fosett</b>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes give war or dates of service)		16 SOCIAL SECURITY NO. <b>217-32-9258</b>	
17. INFORMANT <b>Family records</b>		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: <b>45--</b> IMMEDIATE CAUSE (a) DUE TO <b>Arteriosclerotic heart disease</b> (b) DUE TO <b>Chronic Brain Syndrome</b> (c)		INTERVAL BETWEEN ONSET AND DEATH <b>3-4 years</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)		19 WAS ALTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour <b>11</b> a.m. <b>19</b> p.m.		20d INJURY OCCURRED While <input checked="" type="checkbox"/> at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f (City or town) (County) (State) <b>Joppa</b> (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>11/3</b> , 19 <b>67</b> , to <b>11/7</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>11/3</b> , 19 <b>67</b> , and that death occurred at <b>11/7</b> , 19 <b>67</b> , from causes and on the date stated above.		22a SIGNATURE <b>Ruben S. Sebastian</b>	
22c PHYSICIAN'S NAME (Type) <b>Ruben S. Sebastian MD</b>		22b DATE SIGNED <b>11/9/67</b>	
23a B. RIAL, CREMATION, REMOVAL, ETC. <b>Burial</b>		23b. DATE THEREOF <b>11-9-67</b>	
23c NAME OF CEMETERY OR CREMATORY <b>Dulaney Valley</b>		23d LOCATION (City or Town) (County) (State) <b>Cockyesville Md</b>	
24. FUNERAL DIRECTOR <b>C.F. EVANS &amp; SON 8802 Harford road</b>		25a. REC'D BY REGISTRAR <b>NOV 10 1967</b>	
25b REGISTRAR'S SIGNATURE <b>Charles Jones</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers 1 and 2 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

<div> <div> <div>1</div> <div>2</div> </div> <div> <div>3</div> <div>4</div> </div> </div> <div> <div>5</div> <div>6</div> </div>											
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# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

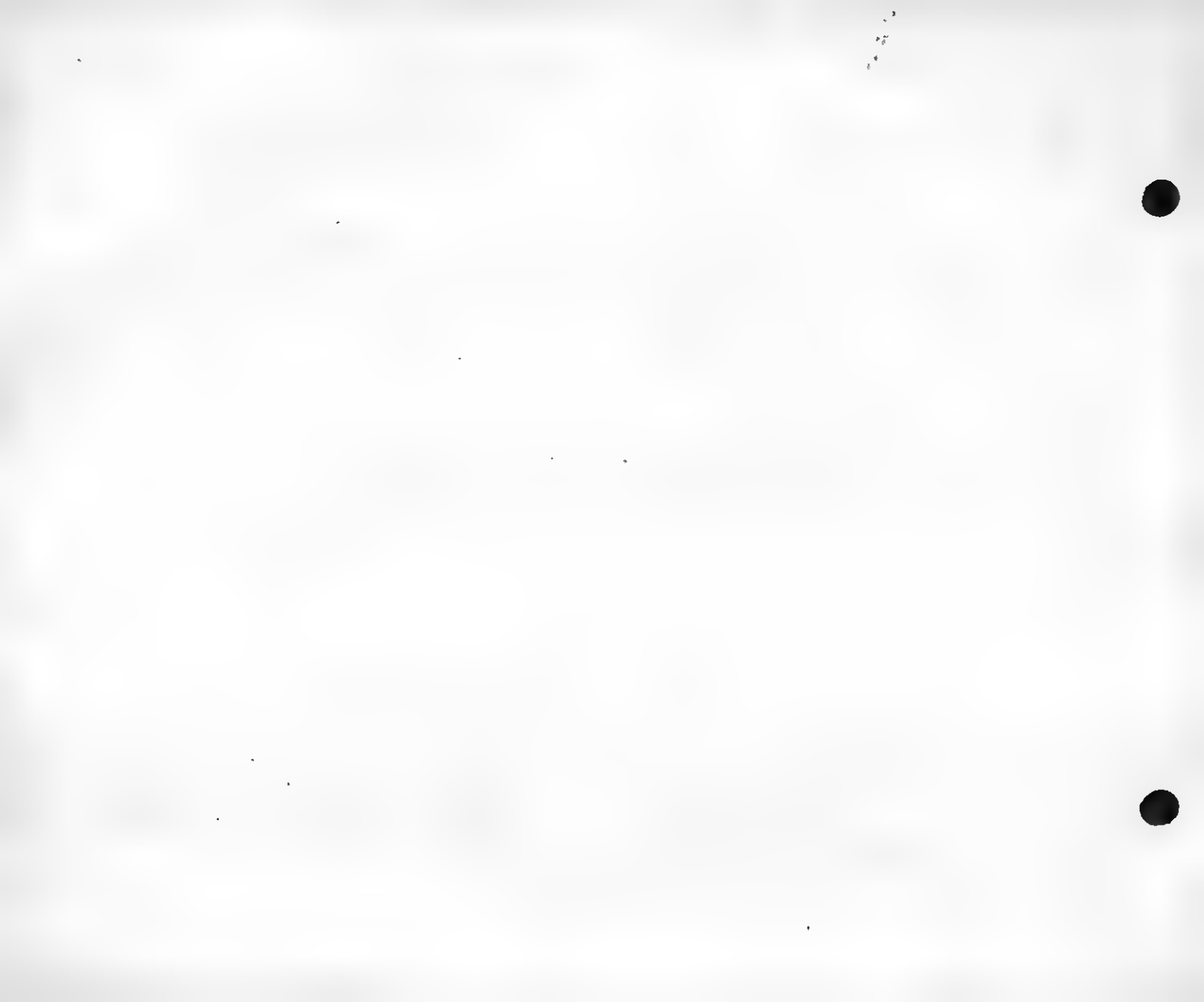
15104

## CERTIFICATE OF DEATH

15106

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission). a. STATE <b>Maryland</b> b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>		c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kingsville 21027</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>St. Joseph Hospital</b>			d. STREET ADDRESS <b>Cedar Lane</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Marie</b> Middle <b>A.</b> Last <b>Smetana</b>			4. DATE OF DEATH Month <b>November</b> Day <b>30</b> Year <b>1967</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12-27-1901</b>	9. AGE (In years last birthday) <b>65</b> yrs	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Homemaker</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>- Vanicek</b>			14. MOTHER'S MAIDEN NAME <b>Unknown</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO <b>212-05-6588B</b>		17. INFORMANT <b>Robert J. Smetana-909 Louis Lane Kingsville</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebellar infarction</b> DUE TO (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Cerebral edema</b>					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>Nov. 26, 1967</b> to <b>Nov. 30, 1967</b> , that (I) (we) last saw the deceased alive on <b>Nov. 30, 1967</b> , and that death occurred at <b>6:13 A.M.</b> from causes and on the date stated above					
22a. SIGNATURE 			22b. DATE SIGNED <b>12/1/67</b>		
22c. PHYSICIAN'S NAME (Type) <b>Reynaldo Orjuela Gomez, M.D.</b>			22d. ADDRESS <b>7620 York Rd. Baltimore, Md. 21204</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>12-4-67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Gardens of Faith</b>	23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Md.</b>		
24. FUNERAL DIRECTOR <b>John C. Miller Inc-6415 Belair Rd.-21206</b>			25a. REC'D BY REGISTRAR <b>DEC 5 1967</b>		25b. REGISTRAR'S SIGNATURE 





## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15107

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>547 N. Lexington Avenue</u>		d. STREET ADDRESS <u>547 N. Lexington Avenue</u>	
3. NAME OF DECEASED (Type or print) <u>Frederick F. Smith, Sr.</u>		4. DATE OF DEATH Month <u>November</u> , Day <u>2</u> , Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>August 2, 1904</u>
10a. USUAL OCCUPATION (Give kind of work done during most of workable even retired) <u>Dist. Ctro. Test.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>also. Co., d.</u>	9. AGE (In years last birthday) <u>63</u> yrs
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Thomas Smith</u>		14. MOTHER'S MAIDEN NAME <u>Nellie Gordon</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>one</u>	
17. INFORMANT <u>Family records</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO <u>Sudden</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item B)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Charles F. O'Donnell</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Charles F. O'Donnell, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		Address (Street, city, town, or county)	
22. DATE SIGNED <u>11/20/67</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>Nov. 2, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Manuel Burial Cemetery</u>	23d. LOCATION (City or town) (County) (State) <u>Lenox, Balto. Co., d.</u>
24. FUNERAL DIRECTOR <u>John Burns' Sons, Towson, Maryland</u>		25a. REC'D BY REG. STRAR <u>Charles Judge</u>	
		25b. REGISTRAR'S SIGNATURE	
		DATE <u>NOV 24 1967</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div>15108</div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</div> <div>CERTIFICATE OF DEATH</div> <div>15108</div>									
Item 8 Film G394 11/10/67 kk									
1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Balt. MD.</b> c. LENGTH OF STAY IN 1b <b>1 MONTH</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Greater BALT MED. Center.</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>Balt.</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Balt. Md.</b> d. STREET ADDRESS <b>3508 Newland Road</b>				
3. NAME OF DECEASED (Type or print) First <b>Louis</b> Middle <b>Golden</b> Last <b>Smith</b>			4. DATE OF DEATH Month <b>11</b> Day <b>4</b> Year <b>1967</b>		6. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
5. SEX <b>M</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>12-16-1887</b>		9. AGE (In years last birthday) <b>69</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>ARMY General</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>US Govern.</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Washington D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Louis <del>Golden</del> Smith</b>					14. MOTHER'S MAIDEN NAME <b>GARRIE <del>Henric</del> GOLDEN</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b>				16. SOCIAL SECURITY NO. <b>212-05-6696</b>		17. INFORMANT <b>air chart.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>150X Chole - Respiratory failure</b> DUE TO (b) <b>Extensive metastases</b> DUE TO (c) <b>CA of Esophagus</b>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <b>10-5, 1967</b> to <b>11-4, 1967</b> , that (I) (we) last saw the deceased alive on <b>11-4, 1967</b> , and that death occurred at <b>6:35 PM</b> from the causes and on the date stated above.									
22a. SIGNATURE <b>Jadecastro</b>					22b. DATE SIGNED <b>11-4-67</b>				
22c. PHYSICIAN'S NAME (Type) <b>MA. JOSEFINA A. de CASTRO</b>					22d. ADDRESS <b>GBMC</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)			
<b>Burial</b>		<b>11/7/1967</b>		<b>Mt. Olivet</b>		<b>Wheaton/Calto Md.</b>			
24. FUNERAL DIRECTOR <b>H.W. Jenkins &amp; Sons Co. 4905 York Rd. Balto. 12, Md.</b>						25a. REC'D BY REGISTRAR <b>NOV 6 1967</b> 25b. REGISTRAR'S SIGNATURE <b>J Charles Young</b>			



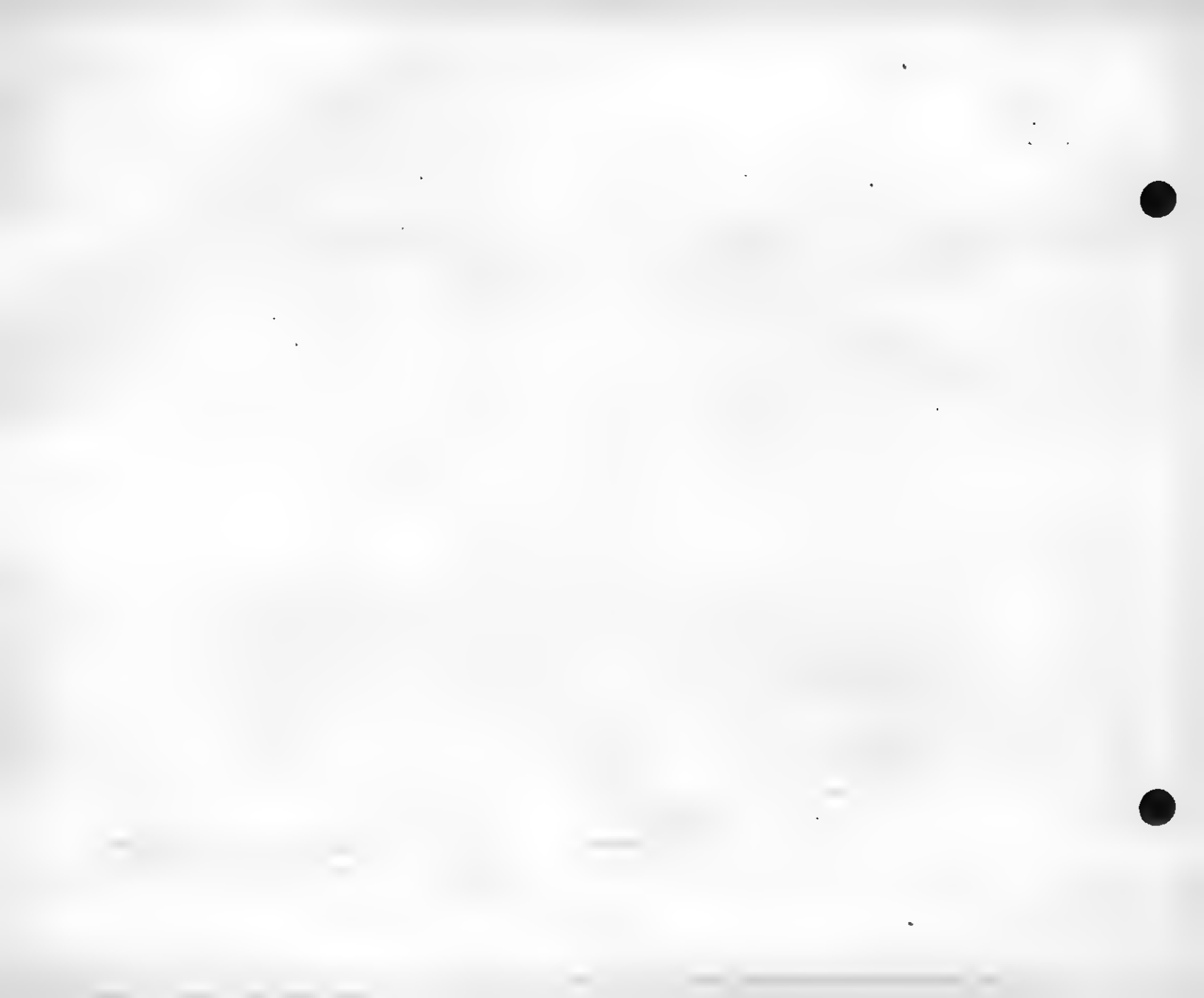
## CERTIFICATE OF DEATH

15109

1 PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Balto.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RANDALLSTOWN</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RANDALLSTOWN</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>BALTO. CO. GEN. HOSP.</u>		d. STREET ADDRESS <u>Box 590 WINANS Rd</u>	
3 NAME OF DECEASED (Type or print) First <u>Sterling</u> Middle <u>C</u> Last <u>Smith</u>		4 DATE OF DEATH Month <u>11</u> - Day <u>13</u> - Year <u>1967</u>	
5 SEX <u>M</u>	6 COLOR OR RACE <u>Negro</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>5-16-11</u>
9 AGE (In years last birthday) <u>56</u> yrs		10 IF UNDER 1 YEAR Months <u>5</u> Days <u>13</u> Hours <u>13</u> Min <u>00</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>WATCHMAN</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u>		12 CITIZEN OF WHAT COUNTRY?	
13 FATHER'S NAME <u>IKE Smith</u>		14 MOTHER'S MAIDEN NAME <u>Georganna WATERS</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT <u>Hosp. Record</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>RESPIRATORY INEFFICIENCY</u> DUE TO (b) <u>Diffuse Pulmonary Edema and</u> DUE TO (c) <u>Bronchopneumonia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			INTERVAL BETWEEN ONSET AND DEATH <u>485</u> - days <u>485</u> - days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not While of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>11-12-1967</u> , to <u>11-13-1967</u> , that (I) (we) last saw the deceased alive on <u>11-13-1967</u> , and that death occurred at <u>4:54 A.M.</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Simon Calle</u>		22b. DATE SIGNED <u>11-13-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>SIMON CALLE</u>		22d. ADDRESS <u>Baltimore Co. Gen. Hospital 5401 Old Court Rd - Randallstown, Md.</u>	
23a. BURIAL, CREMATION, or REMOVA (Specify)	23b. DATE THEREOF <u>11-17-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u>	23d. LOCATION (City or Town) (County) (State) <u>Baltimore Md.</u>
24. FUNERAL DIRECTOR <u>Wilmington Phillip 1727 N. Mount</u>		25a. RECD BY REGISTRAR <u>Charles Judge</u>	
25b. REGISTRAR'S SIGNATURE		DATE <u>NOV 21 1967</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH												
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND												
CERTIFICATE OF DEATH												
15108 - 15110												
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>---</u> ✓						
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Towson</u>				c. LENGTH OF STAY IN 1b <u>1 month</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>						
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Dulaney-Towson Nursing Home</u>						d. STREET ADDRESS <u>509 E. 43rd Street</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>Leo</u> Middle <u>Spampinato</u> Last <u>Spampinato</u>			4. DATE OF DEATH Month <u>November</u> Day <u>27</u> Year <u>1967</u>			5. SEX <u>Male</u>			6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>(contractor) (retired)</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>-----</u>			11. BIRTHPLACE (County & State, or foreign country) <u>Sicily</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Philip Spampinato</u>						14. MOTHER'S MAIDEN NAME <u>Angelina Pistonio</u>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>			16. SOCIAL SECURITY NO. <u>unknown</u>			17. INFORMANT <u>Mary R. Spampinato</u>			Address <u>509 E. 43rd St.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Overwhelming infection</u> DUE TO (b) <u>B. Potius</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (c) <u>decubital ulcers.</u> INTERVAL BETWEEN ONSET AND DEATH <u>3 weeks.</u> <u>"</u>												
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>General A.S. ASHD - probable tumor left kidney.</u>												
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 1965</u> to <u>Nov 27, 1967</u> , that (I) (we) last saw the deceased alive on <u>11/27 1967</u> , and that death occurred at <u>4:44 PM</u> , from the causes and on the date stated above.												
22a. SIGNATURE <u>Arthur Dugan</u>						22b. DATE SIGNED			22c. PHYSICIAN'S NAME (Type) <u>ARTHUR DUGAN</u>			
22d. ADDRESS <u>15 E BIDDLE ST. Balto Md.</u>			22e. M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MEO. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22f. ADDRESS			22g. DATE			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>11/30/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer Cemetery</u>			23d. LOCATION (City, town or county) (State) <u>Baltimore Md.</u>				
24. FUNERAL DIRECTOR <u>John A. Moran, Inc.</u>						24a. ADDRESS <u>3000 E. Balto. St.</u>			24b. REG'D BY REGISTRAR <u>John A. Moran, Inc.</u>			
24c. DATE <u>NOV 30 1967</u>						24d. REGISTRAR'S SIGNATURE <u>John A. Moran, Inc.</u>						





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, and in any event, within 72 hours after death should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
2DM 1/65

<div style="display: flex; justify-content: space-between;"> <div>15209</div> <div> <b>MARYLAND STATE DEPARTMENT OF HEALTH</b>  <b>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</b>  <b>CERTIFICATE OF DEATH</b> </div> <div>15111</div> </div>											
1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>C</b>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>RURAL</b>				c. LENGTH OF STAY IN 1b <b>60 hours</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Greater Baltimore Medical Center</b>						d. STREET ADDRESS <b>2321 madison ave.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>BABY BOY</b> Middle <b>STANCIL</b> Last <b>STANCIL</b>			4. DATE OF DEATH Month <b>NOV.</b> Day <b>15</b> Year <b>19 67</b>			5. SEX <b>male</b>			6. COLOR OR RACE <b>N</b>		
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <b>NOV. 13, 1967</b>			9. AGE (in years last birthday) yrs. <b>60</b>			IF UNDER 1 YEAR Months <b>60</b> Days <b>60</b> Hours <b>60</b> Min. <b>60</b>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore, Maryland</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>Robert Ray Stancil</b>						14. MOTHER'S MAIDEN NAME <b>Rivera</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO. (If yes give war or dates of service)			17. INFORMANT			Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive heart disease</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Malabsorption of colon with obstruction</b>											
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>								
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b>19</b>								
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)			20g. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <b>Nov. 14</b> , 19 <b>67</b> , to <b>Nov. 15</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>Nov. 15</b> , 19 <b>67</b> , and that death occurred at <b>5:45 PM</b> , from the causes and on the date stated above.											
22a. SIGNATURE <b>Lilia C. Baldonado</b>						22b. DATE SIGNED <b>11-15-67</b>			22c. PHYSICIAN'S NAME (Type) <b>LILIA C. BALDONADO, M.D.</b>		
22d. ADDRESS <b>Greater Baltimore Medical Center</b>						22e. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22f. ADDRESS		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>			23b. DATE THEREOF <b>11/16/67</b>			23c. NAME OF CEMETERY OR CREMATORY <b>Greenwood</b>			23d. LOCATION (City, town or county) (State) <b>Baltimore, Md.</b>		
24. FUNERAL DIRECTOR <b>John E. Adams, M.D., M.P.H.</b>						25a. REC'D BY REGISTRAR <b>NOV 22 1967</b>			25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15110

## CERTIFICATE OF DEATH

15112

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>TOWSON</b> c. LENGTH OF STAY IN TB <b>ST. JOSEPH HOSPITAL</b>		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>DUNDALK</b> d. STREET ADDRESS <b>62 S. DUNDALK AVE. #21222</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>DANIEL S. STECK</b>		4. DATE OF DEATH Month <b>NOVEMBER</b> Day <b>8</b> Year <b>1967</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>APRIL 27, 1885</b>
9. AGE (in years lost birthday) <b>82</b> yrs.		10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b>	11. IF UNDER 24 HRS Hours <b>0</b> Min <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of work life, specify if retired) <b>GEN'L. FOREMAN</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>BETHLEHEM STEEL</b>	11. BIRTHPLACE (County & State, or foreign country) <b>SMITHBURG, MARYLAND</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>JOHN STECK</b>	
14. MOTHER'S MAIDEN NAME <b>JENETTE SCHLOSSER</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) <b>NO</b>	
16. SOCIAL SECURITY NO <b>216/10/1317</b>		17. INFORMANT <b>KATHERINE B. STECK-AS IN 2 ABOVE</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Massive pulmonary infarction</b> DUE TO Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>pulmonary thrombo embolism</b> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>Pulmonary emphysema</b>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <del>XX</del> (this hospital) attended the deceased from <b>NOVEMBER 7, 1967</b> , to <b>NOVEMBER 8, 1967</b> , that <del>XX</del> (we) last saw the deceased alive on <b>NOVEMBER 8, 1967</b> , and that death occurred at <b>12:30 AM</b> from causes and on the date stated above.			
22a. SIGNATURE 		22b. DATE SIGNED <b>11/8/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Reynaldo Orjuela-Gomez, M.D.</b>		22d. ADDRESS <b>7620 York Rd., Towson, Md. 21204</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>11/11/1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>OAK LAWN</b>	23d. LOCATION (City or Town) (County) (State) <b>BALTO. CO., MD.</b>
24. FUNERAL DIRECTOR <b>W. Brooks Bradley</b>		25a. REC'D BY REGISTRAR <b>NOV 10 1967</b>	
25b. REGISTRAR'S SIGNATURE 		25c. ADDRESS <b>DUNDALK, MARYLAND</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



## CERTIFICATE OF DEATH

15111

15113

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <b>Baltimore Co.</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b> c. LENGTH OF STAY IN 1b <b>11/28/67</b>		2 USUAL RESIDENCE (Where deceased lived, if not in residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville Baltimore 21225</b> d. STREET ADDRESS <b>4705 Fernside Ave.</b> <b>5743 Edmondson Ave.</b>	
3 NAME OF DECEASED (Type or print) First <b>Margaret</b> Middle <b>Estelle</b> Last <b>Steel</b>		4 DATE OF DEATH Month <b>November</b> Day <b>25</b> Year <b>1967</b>	
5 SEX <b>Female</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>Aug 28, 1880</b>
9. AGE (in years last birthday) <b>87</b> yrs		10 UNDER 1 YEAR IF UNDER 24 HRS Months <b>1</b> Days <b>1</b> Hours <b>1</b> Min <b>1</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore, Maryland</b>		12 C.T.ZEN OF WHAT COUNTRY? <b>U. A. A.</b>	
13. FATHER'S NAME <b>George Henry Thayer</b>		14. MOTHER'S MAIDEN NAME <b>Emily ?</b>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Self</b>		Address <b>Ridgeway Manor Catonsville, Md</b>	
18 CAUSE OF DEATH (Enter only one cause per line, for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY <b>331X</b> IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> DUE TO (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <b>1 hr</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1B)	
20c TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>1 Jan</b> , 19 <b>66</b> , to <b>25 Nov 1967</b> , that (I) (we) last saw the deceased alive on <b>23 Nov 1967</b> , and that death occurred at <b>12:30 AM</b> , from causes and on the date stated above.			
22a SIGNATURE <b>William Goodman</b> M.D.		22b DATE SIGNED <b>27 Nov 67</b>	
22c PHYSICIAN'S NAME (Type) <b>WILLIAM GOODMAN M.D.</b>		22d ADDRESS <b>1331 S. PULASKI RD Spring Rd-21227</b>	
23a BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b DATE THEREOF <b>11/28/67</b>	23c NAME OF CEMETERY OR CREMATORY <b>Good Shepherd Cemetery</b>	23d LOCATION (City or Town) (County) (State) <b>Ellicott City, Md. Howard Co. Md.</b>
24 FUNERAL DIRECTOR <b>McCully Funeral Home</b>		25a REC'D BY REGISTRAR <b>25b REGISTRAR'S SIGNATURE</b>	
25a ADDRESS <b>237 Patapsco Ave. 21225</b>		DATE <b>NOV 28 1967</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filed, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15112

CERTIFICATE OF DEATH

15114

1 PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>		c. LENGTH OF STAY IN 1b <b>2 DAYS</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>VETERANS ADMINISTRATION HOSPITAL</b>		d. STREET ADDRESS <b>829 N. EUTAW STREET</b>	
3 NAME OF DECEASED (Type or print) First Middle Last <b>WILBUR BYRON STEINBAUGH</b>		4 DATE OF DEATH Month Day Year <b>NOVEMBER 2, 19 67</b>	
5 SEX <b>MALE</b>	6 COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>2/20/24</b>
9 AGE (In years last birthday) yrs <b>43</b>		10 IF UNDER 1 YEAR Months Days Hours Min <b>IF UNDER 24 HRS</b>	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SALESMAN</b>		10b KIND OF BUSINESS OR INDUSTRY <b>ELECTRICAL INDUSTRY WASHINGTON, D.C.</b>	
11 BIRTHPLACE (County & State, or foreign country) <b>U.S.A.</b>		12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>WILLIAM STEINBAUGH</b>		14. MOTHER'S MAIDEN NAME <b>BESSIE MAWSON</b>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>YES WWII</b>		16 SOCIAL SECURITY NO <b>578 20 45 65</b>	
17 INFORMANT <b>CLINICAL RECORDS, VAH, FT. HOWARD, MD.</b>		Address	
18 CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARCINOMA OF BLADDER WITH METASTASES</b> <b>XXXX</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>BRONCHOPNEUMONIA, BILATERAL, UNDETERMINED ORGANISM</b> DUE TO (c)		INTERVAL BETWEEN DEATH AND DEATH <b>UNKNOWN</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>OCT 31, 1967</b> , to <b>NOV 2, 1967</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>NOV 2, 1967</b> , and that death occurred at <b>5:25AM</b> , from causes and on the date stated above.			
22a SIGNATURE <i>Joseph J. Mowad</i>		22b DATE SIGNED <b>11/3/67</b>	
22c PHYSICIAN'S NAME (Type) <b>JOSEPH J. MOWAD, M. D.</b>		22d ADDRESS <b>VAH FORT HOWARD, MARYLAND</b>	
23a BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b DATE THEREOF <b>11/7/67</b>	23c NAME OF CEMETERY OR CREMATORY <b>BALTIMORE NATIONAL</b>	23d LOCATION (City or Town) (County) (State) <b>BALTIMORE, MARYLAND</b>
24 FUNERAL DIRECTOR <i>Joseph J. Zannino</i>		25a REC'D BY REGISTRAR <b>NOV 15 1967</b>	
25b REGISTRAR'S SIGNATURE <i>Charles Judge</i>		25c ADDRESS <b>257 S. CONKLING ST. BALTIMORE, MD.</b>	

VR A15 (4)  
25M 1/67





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

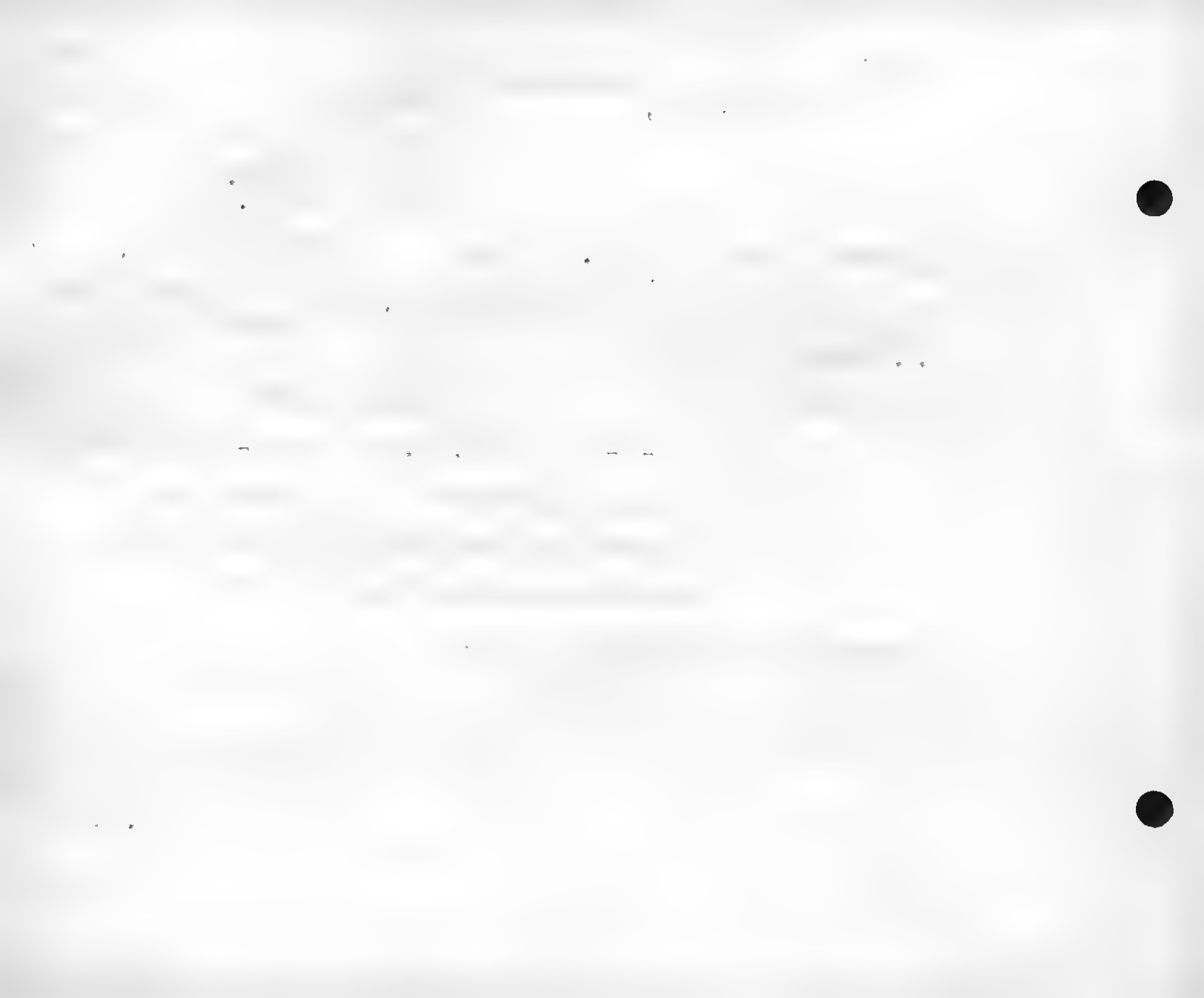
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>Catonsville-21228,</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institut on Residence before adm ssion) a STATE <b>Maryland</b> b COUNTY <b>Baltimore</b>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c LENGTH OF STAY IN 1b	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Spring Grove State Hospital</b>		e. IS RES DENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <b>Lloyd A. STERNER</b>		4 DATE OF DEATH Month <b>November 11,</b> Day <b>67</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>August 27, 1911</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>T.V. Repair</b>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years lost b rthday) <b>56</b> yrs
11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12 CIT ZEN OF WHAT COUNTRY? <b>US</b>	
13. FATHER'S NAME <b>Elmer STERNER</b> <b>Lloyd E. Sterner</b>		14. MOTHER'S MAIDEN NAME <b>Margaret ALEXANDER</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16 SOCIAL SECURITY NO <b>214-09-3488</b>	
17 INFORMANT <b>Wife: Mrs. Mary STERNER</b>		Address <b>Catonsville, -128 Rosewood Ave</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I: DEATH CAUSED BY IMMEDIATE CAUSE (a) <b>Acute Heartfailure</b> (sudden death) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Arteriosclerotic Heart Disease (Myocardial infarction)</b> DUE TO (c) <b>Bilateral Pulmonary Emphysema (Chest-X-ray)</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDIT ON GIVEN IN PART I (a) <b>Malnutrition on a psychogenic basis.</b>		19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <b>no accident</b>	
20c TIME OF INJURY Month, Day, Year Hour a.m. <b>none</b> 19	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that <b>(1) (this hospital)</b> attended the deceased from <b>October 4, 1967</b> to <b>November 11, 1967</b> , that <b>(1) (we)</b> last saw the deceased alive on <b>November 11, 1967</b> , and that death occurred at <b>2:25 PM</b> from causes and on the date stated above.			
22a SIGNATURE <b>Dr Imre Kopits</b>		22b DATE SIGNED <b>Nov. 11, 1967</b>	
22c PHYSICIAN'S NAME (Type) <b>Dr Imre Kopits</b>		22d ADDRESS <b>Spring Grove State Hospital</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>11/15/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Boonsboro Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Boonsboro Md.</b>
24. FUNERAL DIRECTOR <b>Hubbard Funeral Home, 4107 Wilkens Ave. 21229</b>		25a REC'D BY REGISTRAR DATE <b>NOV 14 1967</b>	25b REGISTRAR'S SIGNATURE <b>William J. Jones</b>



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

15114

15116

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb. <u>Baltimore</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>St. Josephs Hospital</u>		e. STREET ADDRESS <u>4402 Arizona Avenue</u>	
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>E</u> Last <u>STOCKMAN</u>		4. DATE OF DEATH Month <u>November</u> Day <u>18</u> Year <u>67</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-10-29 88</u>
9. AGE (in years last birthday) <u>78</u> yrs		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min <u>  </u>	11. IF UNDER 24 HRS Hours <u>  </u> Min <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Thomas Finn</u>		14. MOTHER'S MAIDEN NAME <u>Mary Brazier</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unk.</u>	
17. INFORMANT <u>Mrs. Marie Nelson</u>		Address <u>(Same)</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrhythmia</u> DUE TO (b) <u>Coronary artery disease</u> DUE TO (c) <u>arteriosclerotic cardiovascular disease</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (1) (this hospital) attended the deceased from <u>18 November, 1967</u> to <u>November 18, 67</u> , that (1) (we) last saw the deceased alive on <u>November 18, 67</u> , and that death occurred on <u>5 P.M.</u> , from causes on and on the date stated above.			
22a. SIGNATURE <u>Gayoso</u>		22b. DATE SIGNED <u>11-18-67</u>	
22c. PHYSICIAN'S NAME (Typed) <u>Gayoso M.D.</u>		22d. ADDRESS <u>7620 York Road, Baltimore 21204</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THE DEED <u>11/22/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer Cemetery</u>	23d. LOCATION (City or town) (County) (State) <u>Baltimore, Md.</u>
24. FUNERAL DIRECTOR <u>Leonard J. Ruck, Inc. Balto. Md. 21214</u>		25a. REC'D BY REGISTRAR DATE <u>NOV 20 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 1003. Page 5 may be retained for your files.

TO MEDICAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 PLACE OF DEATH a COUNTY <b>Baltimore</b> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE <b>Maryland</b> b COUNTY <b>Baltimore</b>			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c LENGTH OF STAY IN 1b		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>			
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>334 Stafford Drive</b>				d STREET ADDRESS <b>334 Stafford Drive</b>		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <b>Lillian B Summers</b>		First Middle Last		4 DATE OF DEATH Month <b>November</b> Day <b>1</b> Year <b>1967</b>			
5 SEX <b>Female</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>1/29/05</b>		9 AGE (In years last birthday) <b>62</b> yrs	F UNDER 1 YEAR Months Days Hours Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (State or foreign country) <b>Montanna</b>		12 CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John Boyd</b>				14. MOTHER'S MAIDEN NAME <b>Helena Taggart</b>			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16 SOCIAL SECURITY NO		17 INFORMANT <b>Mrs. Marilyn B. Towles, 334 Stafford Drive</b>		Address <b>21228</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH CAUSED BY IMMEDIATE CAUSE (a) <b>Cardio-Vascular Disease</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO (c) <b>Sudden</b>						INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART II(a)							
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Dr. James N. Frederick</b>		EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22 DATE SIGNED <b>11/2/67</b>	
23a BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b DATE THEREOF <b>11/4/67</b>		23c NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery</b>		23d LOCATION (City or Town) (County) (State) <b>Baltimore Md.</b>	
24 FUNERAL DIRECTOR <b>Howard H. Hubbard, 4107 Wilkens Ave., 21229</b>				25a REC'D BY REGISTRAR <b>NOV 4 1967</b>		25b REGISTRAR'S SIGNATURE <b>O'Connor Judge</b>	



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1-2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a COUNTY <u>Baltimore</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE <u>Md</u> b COUNTY <u>Balto</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore - Carney</u>		c LENGTH OF STAY IN 1b <u>18 yrs</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>4507 Funder Lake 34</u>		d STREET ADDRESS <u>4507 Funder Lake</u>	
3 NAME OF DECEASED (Type or print) <u>BLAINE MILLE SWARTZ</u>		4 DATE OF DEATH Month <u>Nov</u> Day <u>3</u> Year <u>1967</u>	
5 SEX <u>Male</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>9-28-22</u>
9 AGE (In years lost birthday) <u>45</u> yrs		IF UNDER 1 YEAR Months <u>3</u> Days <u>19</u> Hours <u>67</u> Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Purchasing Agent</u>		10b KIND OF BUSINESS OR INDUSTRY <u>Aircraft Arm.</u>	
11 BIRTHPLACE (State or foreign country) <u>New York</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13 FATHER'S NAME <u>Harry M. Swartz</u>		14 MOTHER'S MAIDEN NAME <u>Agnes I.</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes WW2</u>		16 SOCIAL SECURITY NO <u>054-12-0288</u>	
17 INFORMANT <u>Family records</u>		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Atherosclerosis, Coronary Sclerosis</u> DUE TO <u>Dissection</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <u>Dissection</u> (c) <u>Dissection</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Undet</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) <u>Diabetes mellitus</u>		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b) <u>X</u>	
20 TIME OF INJURY Month Day, Year Hour a.m. <u>X</u> p.m. <u>19</u>		20a INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20c PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.) <u>X</u>		20f (City or town; (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) <u>John C. Hyle</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street city town, or county) <u>7527 Belair Rd 36</u>	
23a BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		23b DATE THEREOF <u>11-6-67</u>	
23c NAME OF CEMETERY OR CREMATORY <u>Dulaney Valley Cem.</u>		23d LOCATION (city or town) <u>Balto Co Md.</u>	
24 FUNERAL DIRECTOR <u>C.E. EVANS &amp; SON 8802 Harford road</u>		25a REC'D BY REGISTRAR <u>NOV 7 1967</u>	
25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>			





# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form FMS-1. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

## MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15119

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>BALTO</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Essex</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Essex</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>50 High Seas Ct.</b>		d. STREET ADDRESS <b>50 High Seas Ct.</b>	
3. NAME OF DECEASED (Type or print) First <b>ARLENE</b> Middle <b>MARIE</b> Last <b>SYMAN</b>		4. DATE OF DEATH Month <b>November</b> Day <b>21</b> Year <b>1967</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>APR, 5 1916</b>
9. AGE (in years lost birthday) <b>51</b> yrs.		10. IF UNDER 1 Year Months <b>5</b> Days <b>1</b> Hours <b>51</b> Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>—</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>—</b>	
11. BIRTHPLACE (State or foreign country) <b>W. VA.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>JOHNSON D. BAILEY</b>		14. MOTHER'S MAIDEN NAME <b>?</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>—</b>	
17. INFORMANT <b>DAVID A SYMAN</b>		Address <b>ABOVE</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Skull fracture</b> <b>XXXXXX</b> (b) <b>Subdural hematoma</b> <b>XXXXXX</b> (c) <b>Contusion severe of brain</b>			INTERVAL BETWEEN ONSET AND DEATH <b>—</b>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>—</b>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <b>Subject fell down stairs</b>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <b>Subject fell down stairs</b>	
20c. TIME OF INJURY Month, Day, Year Hour <b>XXXX</b> p.m. <b>11 21</b> 19 <b>67</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) <b>Home</b>		20f. (City or town) (County) (State) <b>Essex Balto. Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Edward F. Wilson</b>		22. DATE SIGNED <b>November 22, 1967</b>	
EXAMINER'S NAME (Type) <b>Edward F. Wilson, M.D.</b>		Address (Street, city, town, or county) <b>—</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>	23b. DATE THEREOF <b>11/23/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>ROSELAWN CEM.</b>	23d. LOCATION (City or town) (County) (State) <b>BLUEFIELD W. VA.</b>
24. FUNERAL DIRECTOR <b>J.G. CONNELLY SONS</b>		25a. REC'D BY REGISTRAR <b>300 MACE</b>	
25b. REGISTRAR'S SIGNATURE <b>—</b>		DATE <b>NOV 27 1967</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

151118

15120

1 PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Towson</b>		c. LENGTH OF STAY IN 1b <b>years</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Chesapeake Manor Nursing Home</b>		d. STREET ADDRESS <b>5746 Cedonia Avenue (6)</b>	
3 NAME OF DECEASED (Type or print) <b>William</b> First Middle Last <b>G. Tarr</b>		4 DATE OF DEATH Month <b>November</b> Day <b>22</b> Year <b>1967</b>	
5 SEX <b>Male</b>	6 COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>April 20, 1893</b>
9 AGE (In years last birthday) <b>74</b> yrs		10 IF UNDER 1 YEAR Months Days Hours Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Building Manager</b>		10b KIND OF BUSINESS OR INDUSTRY <b>Maryland Casu. Co. Baltimore City</b>	
11 BIRTHPLACE (County & State, or foreign country) <b>U.S.A.</b>		12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13 FATHER'S NAME <b>William H. Tarr</b>		14 MOTHER'S MAIDEN NAME <b>Agnes Peterson</b>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16 SOCIAL SECURITY NO <b>212 10 3034</b>	
17 INFORMANT <b>Mrs. Louise E. Tarr</b>		Address <b>5746 Cedonia Ave.</b>	
18 CAUSE OF DEATH (Enter only one cause per PART DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Arteriosclerotic Cardiovascular Disease</b> DUE TO (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH <b>18 yrs</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH: BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>Nov 27, 1965</b> to <b>Nov 22, 1967</b> , that (I) (we) last saw the deceased alive on <b>Nov 21, 1967</b> , and that death occurred at <b>4 P</b> - M, from causes and on the date stated above			
22a. SIGNATURE <b>Adam G. Swiss</b>		22b. DATE SIGNED <b>Nov 24, 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>ADAM G SWISS</b>		22d. ADDRESS <b>6232 Belair Rd. Balto; Md 21206</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>11/25/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Parkwood Cem.</b>	23d. LOCATION (City or Town) (County) (State) <b>Overlea Balto. Md.</b>
24. FUNERAL DIRECTOR <b>Lassahn Funeral Home</b>		ADDRESS <b>7401 Belair Road</b>	
25a. REC'D BY REGISTRAR <b>NOV 27 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Wm. J. Judge</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

15118

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

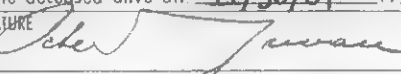

CERTIFICATE OF DEATH

15121

1. PLACE OF DEATH a. COUNTY <b>BALTO.</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if at institution; Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>BALTO.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ESSEX</b>		c. LENGTH OF STAY IN 1b <b>ESSEX</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>2215 CORALTHORN RD</b>		d. STREET ADDRESS <b>2215 CORALTHORN RD.</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>BETTY JEAN TAYLOR</b>		4. DATE OF DEATH Month Day Year <b>NOV. 9 1967</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>APR. 22 1923</b>
9. AGE (In years lost birthday) <b>44 yrs</b>		10. IF UNDER 1 YEAR Months Days Hours Min. <b>44</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>PA.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>CLARENCE REED</b>		14. MOTHER'S MAIDEN NAME <b>LAURABELLE TENNETT</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>—</b>	
17. INFORMANT <b>JAMES TAYLOR</b>		Address <b>ABOVE</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Anoxia</b> DUE TO <b>151X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Generalized carcinomatosis</b> DUE TO <b>3-4 mos</b> (c) <b>Basal ganglia Ca</b> DUE TO <b>6 mos</b>			INTERVAL BETWEEN ONSET AND DEATH <b>3-4 mos</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 8)	
20c. TIME OF INJURY Month, Day Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>July, 1967</b> , to <b>11/9, 1967</b> , that (I) (we) last saw the deceased alive on <b>11/8, 1967</b> , and that death occurred at <b>11/9, 1967</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>J. BLATT, MD</b>		22b. DATE SIGNED <b>11/10/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>J. BLATT, MD</b>		22d. ADDRESS <b>406 Eastern Blvd East, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>11/13/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>BALTO. NATL.</b>	23d. LOCATION (City or Town) (County) (State) <b>BALTO. MD</b>
24. FUNERAL DIRECTOR <b>J.G. CORNELLY SONS</b>		25a. REC'D BY REGISTRAR <b>300 MACE</b>	
25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>		DATE <b>NOV 13 1967</b>	



VR A15 (4)  
25M 1/67

1 PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution or Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>VETERANS ADMINISTRATION HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First <b>HENRY</b> Middle <b>--</b> Last <b>TAYLOR</b>		4 DATE OF DEATH Month <b>NOVEMBER</b> Day <b>30</b> Year <b>19 67</b>	
5 SEX <b>MALE</b>		6 COLOR OR RACE <b>NEGRO</b>	
7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH <b>12/28/87</b>	
9 AGE (In years last birthday) <b>79</b> yrs		10 UNDER 1 YEAR Months <b>7</b> Days <b>28</b>	
11 US. AL. OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LABORER</b>		12 KIND OF BUSINESS OR INDUSTRY <b>CONSTRUCTION</b>	
13 BIRTHPLACE (County & State, or foreign country) <b>BALTIMORE, MARYLAND</b>		14 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
15 FATHER'S NAME <b>DALLAS TAYLOR</b>		16 MOTHER'S MAIDEN NAME <b>LENA MONROE</b>	
17 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b> (If yes give war or dates of service) <b>WW I</b>		18 SOCIAL SECURITY NO. <b>215 07 59 99</b>	
19 INFORMANT <b>CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.</b>		Address	
19a CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>BRONCHOPNEUMONIA</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) <b>METASTATIC CARCINOMA</b> DUE TO (c) <b>ADENOCARCINOMA OF PROSTATE</b>		INTERVAL BETWEEN ONSET AND DEATH <b>DAYS</b> <b>1 YEAR</b> <b>4 YEARS</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1B)	
20c TIME OF INJURY Month, Day, Year Hour <b>a.m.</b> <b>19</b> p.m.		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>4/10/67</b> , 19 <b>67</b> , to <b>11/30/67</b> , 19 <b>67</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>11/30/67</b> , 19 <b>67</b> , and that death occurred at <b>5:35 PM</b> from causes and on the date stated above.			
22a SIGNATURE 		22b DATE SIGNED <b>12/1/67</b>	
22c PHYSICIAN'S NAME (Type) <b>PETER V. JUVAN, M. D.</b>		22d ADDRESS <b>VAH FORT HOWARD, MARYLAND</b>	
23a BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b DATE THEREOF <b>Dec 5/67</b>	
23c NAME OF CEMETERY OR CREMATORY <b>St. Paul's North Cemetery</b>		23d LOCATION (City or town) (County) (State) <b>530, Federal Ave. Md</b>	
24 FUNERAL DIRECTOR <b>ELLIOTT FUNERAL HOME</b>		25a REC'D BY REGISTRAR <b>DEC 5 1967</b>	
25b REGISTRAR'S SIGNATURE 		25c ADDRESS <b>N. CAROLINE ST. BALTIMORE, MD.</b>	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 145 (4)  
2DM 1/65

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
15121  
CERTIFICATE OF DEATH  
5'23

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>235 Ridgeway Rd.</u>		d. STREET ADDRESS <u>235 Ridgeway Rd.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>WILLIAM MAURICE TEMMINK</u>		4. DATE OF DEATH Month Day Year <u>November 6 1967</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 29, 1896</u>
9. AGE (In years last birthday) <u>71</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Attorney, VP &amp; D.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Underwriting</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Howard County, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Henry Temmink</u>		14. MOTHER'S MAIDEN NAME <u>Katherine Kuhns</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>		16. SOCIAL SECURITY NO. <u>215-10-1398</u>	
17. INFORMANT <u>Mrs Mary M. Temmink</u>		Address <u>235 Ridgeway Rd</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of gall bladder with metastases</u> DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Mar. 2, 1957</u> to <u>Nov 6, 1967</u> , that (I) (we) last saw the deceased alive on <u>Nov 3, 1967</u> , and that death occurred at <u>7:45</u> AM, from the causes and on the date stated above.			
22a. SIGNATURE <u>John A. Nesbitt, Jr.</u>		22b. DATE SIGNED <u>11-6-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>JOHN A. NESBITT, JR</u>		22d. ADDRESS <u>1009 Frederick Rd Baltimore Md 21228</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Nov 8, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cemt. Baltimore Maryland</u>	23d. LOCATION (City, town or county) (State)
24. FUNERAL DIRECTOR <u>STERLING FUNERAL ESTATE</u> <u>Catonsville, Md.</u>		25a. REC'D BY REGISTRAR <u>ANN 9 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers - pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ANNE ARUNDEL</b> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>TRACEYS LANDING</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>VETERANS ADMINISTRATION HOSPITAL</b>		d. STREET ADDRESS <b>ROUTE 2</b>	
3 NAME OF DECEASED (Type or print) First <b>DAVID</b> Middle <b>THOMAS</b> Last <b>THOMAS</b>		4. DATE OF DEATH Month <b>NOVEMBER</b> Day <b>24</b> Year <b>19 67</b>	
5 SEX <b>MALE</b>	6. COLOR OR RACE <b>NEGRO</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8/30/95</b>
9 AGE (In years last birthday) <b>72</b> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FARMER</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>JEWELL, MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>THOMAS THOMAS</b>		14. MOTHER'S MAIDEN NAME <b>HENRIETTA GRAY</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>YES WW I</b>		16. SOCIAL SECURITY NO <b>218 24 68 37</b>	
17. INFORMANT <b>CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>BRONCHOPNEUMONIA</b> 441X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>STATUS POST GASTRECTOMY</b>		INTERVAL BETWEEN ONSET AND DEATH <b>HOURS</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <b>19</b> o.m. p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>11/3/67</b> , 19 to <b>11/24/67</b> , 19, that (X) (we) last saw the deceased alive on <b>11/24/67</b> , 19, and that death occurred at <b>11:40AM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>Dr. Adhox B. Bant...</b>		22b. DATE SIGNED <b>11/24/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>MADHAV D. BARMANFURKAR</b>		22d. ADDRESS <b>VAH FORT HOWARD, MARYLAND</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>11-28-1967</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>FRIENDSHIP</b>		23d. LOCATION (City or town) (County) (State) <b>FRIENDSHIP, MARYLAND</b>	
24. FUNERAL DIRECTOR <b>William Reese #</b>		25a. REC'D BY REGISTRAR <b>NOV 27 1967</b>	
ADDRESS <b>REECE FUNERAL HOME ANNAPOLIS, MARYLAND</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers: Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
15123 CERTIFICATE OF DEATH 15126											
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>				c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cockeysville</b>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>House in the Pines, Catonsville</b>						d. STREET ADDRESS <b>Knox Ave.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Lulu</b> Middle <b>Myrtle</b> Last <b>Thompson</b>						4. DATE OF DEATH Month <b>11</b> Day <b>24</b> Year <b>1967</b>					
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Cau.</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Feb. 18, 1887</b>		9. AGE (In years last birthday) <b>80</b> yrs.		IF UNDER 1 YEAR Months <b>11</b> Days <b>24</b> Hours <b>19</b> Min. <b>67</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Bar Maid</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Tavern</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>			12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		
13. FATHER'S NAME <b>John Thomas Thompson</b>						14. MOTHER'S MAIDEN NAME <b>Keziah Ellen Johnson</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>				16. SOCIAL SECURITY NO. <b>217-26-3199</b>		17. INFORMANT <b>Mr. John T. Thompson, Same as # 2</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> 4. DUE TO <b>Arteriosclerotic Cardio Vasc. Disease, Class III</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH <b>2 wks</b> <b>1037</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour <b>a.m.</b> <b>19</b> p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>11-11-</b> 19 <b>67</b> , to <b>11-24-</b> 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>11-22-</b> 19 <b>67</b> , and that death occurred at <b>2:54 AM</b> , from the causes and on the date stated above.											
22a. SIGNATURE <b>Wilmer K. Gallagher</b>						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>11-24-1967</b>			
22c. PHYSICIAN'S NAME (Type) <b>Wilmer K. Gallagher</b>						22d. ADDRESS <b>6309 Frederick Ave Baltimore 28, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Nov. 27, 1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Carmel Cemetery</b>				23d. LOCATION (City, town or county) (State) <b>Parkton, Balto. Co., Md.</b>			
24. FUNERAL DIRECTOR <b>Wm. Cook-Brooks Towson,</b>						ADDRESS <b>1050 York Road</b>		25a. REC'D BY REGISTRAR <b>NOV 28 1967</b>		25b. REGISTRAR'S SIGNATURE	
						Towson, Maryland <b>21204</b>					

1900

1900

1900

John Thomas 1900

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15124

15127

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1 PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution or Residence before admission) a. STATE <b>D. C.</b> b. COUNTY <b>MD</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Owings Mills</b>		c. LENGTH OF STAY IN 16 <b>16 yrs.</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Rosewood State Hospital</b>		d. STREET ADDRESS <b>12912 Valor Drive, S.E.</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Dorothy Louise TODD</b>		4. DATE OF DEATH Month Day Year <b>11 9 19 67</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6-1-47</b>
9. AGE (In years last birthday) <b>20 yrs</b>		10. IF UNDER 1 YEAR Months Days <b>20</b>	11. IF UNDER 24 HRS Hours Min <b>20</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Dependent</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>none</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Washington, D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>James Clifford Todd</b>		14. MOTHER'S MAIDEN NAME <b>Dorothy Edna Follin</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO <b>none</b>	
17. INFORMANT <b>Rosewood Records, Owings Mills, Maryland</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Insufficiency</b> <b>4222</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO	
19. INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>		20. PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Epilepsy, congenital, etiology not determined.</b>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		21b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 1 of item 18) <b>none</b>	
22a. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	22b. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	22c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>none</b>	22d. (City or town) (County) (State) <b>none</b>
21. I certify that (a) (this hospital) attended the deceased from <b>9/14</b> , 19 <b>51</b> , to <b>11/9</b> , 19 <b>67</b> , that (b) (we) last saw the deceased alive on <b>11/9</b> 19 <b>67</b> , and that death occurred at <b>11:30 a.m.</b> causes and on the date stated above			
22a. SIGNATURE <b>Harry G. Butler</b>		22b. DATE SIGNED <b>11-10-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Harry G. Butler, M.D.</b>		22d. ADDRESS <b>Rosewood St. Hosp., Owings Mills, Md.</b>	
23a. BURIAL, CREMATION, or other disposition <b>BURIAL</b>	23b. DATE THEREOF <b>11/13/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>TRINITY MEMORIAL PARK</b>	23d. LOCATION (City or Town) (County) (State) <b>WALDORE, MD.</b>
24. FUNERAL DIRECTOR <b>W.W. CHAMBERS CO.</b>		25. REC'D BY REGISTRAR <b>NOV 13 1967</b>	
26. ADDRESS <b>517 11th St. S.E.</b>		27. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	





CERTIFICATE OF DEATH

15128

15125

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
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1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>MD</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mount Wilson</b>		c. LENGTH OF STAY IN 1b <b>2 mo 9 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Mount Wilson State Hospital</b>		e. STREET ADDRESS <b>1210 Smithson St.</b>	
3. NAME OF DECEASED (Type or print) <b>CLARENCE TURNER</b>		4. DATE OF DEATH Month <b>11</b> / Day <b>7</b> / Year <b>1967</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1/1/1909</b>
9. AGE (In years lost birthday) <b>58 yrs</b>		10. IF UNDER 1 YEAR Months <b>11</b> Days <b>7</b> Hours <b>1</b> Min <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Candy maker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Candy maker</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>not known</b>		14. MOTHER'S MAIDEN NAME <b>KATIE TURNER</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <b>149-05-4132</b>	
17. INFORMANT <b>Records at Mt. Wilson State Hospital</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>BRONCHOPNEUMONIA</b> DUE TO (b) <b>BRONCHOGENIC CARCINOMA</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>8/28/1962</b> , to <b>11/7/1967</b> , that (I) (we) last saw the deceased alive on <b>11/7/1967</b> , and that death occurred at <b>6:05 AM</b> , from causes and on the date stated above			
22a. SIGNATURE <b>William Newcomer</b>		22b. DATE SIGNED <b>11/7/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>William Newcomer, M.D.</b>		22d. ADDRESS <b>Mount Wilson, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>11-11-67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Arbutus Mem. PK.</b>	23d. LOCATION (City or Town) (County) (State) <b>Arbutus, Md.</b>
24. FUNERAL DIRECTOR <b>Nelson Funeral Home 1348 A. Edmonson St.</b>		25a. REC'D BY REGISTRAR <b>NOV 8 1967</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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VR A15 (4)  
 25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15125		15129	
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>English Consul</b>	c LENGTH OF STAY in 1b	c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>English Consul</b>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>2815 Rose Ave.</b>		d STREET ADDRESS <b>2815 Rose Ave. 21227</b>	
3. NAME OF DECEASED (Type or print) First <b>Conrad</b> Middle <b>H</b> Last <b>Unger</b>		4. DATE OF DEATH Month <b>11</b> Day <b>21</b> Year <b>1967</b>	
5 SEX <b>Male</b>	6 COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>2/7/86</b>
9 AGE (In years last birthday) <b>81 yrs</b>		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Gov.</b>	
11 BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12 CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Herman Unger</b>		14. MOTHER'S MAIDEN NAME <b>Johanna - - -</b>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO <b>220-44-0807</b>	
17. INFORMANT <b>Mrs. Catherine A. Unger, 2815 Rose Ave.</b>		Address <b>21227</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> 4201 DUE TO (b) <b>Atherosclerotic C-V Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>7 hours</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 1b)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>Nov. 21, 1967</b> , to <b>Nov. 21, 1967</b> , that (I) (we) lost the deceased alive on <b>Nov 21, 1967</b> , and that death occurred at <b>M</b> , from causes and on the date stated above.			
22a SIGNATURE <b>Dr. Morris W. Steinberg</b>		22b DATE SIGNED <b>11/22/67</b>	
22c PHYSICIAN'S NAME (Type) <b>Dr. Morris W. Steinberg</b>		22d ADDRESS <b>3913 Hollins Ferry Rd. Lansdowne</b>	
23a BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b DATE THEREOF <b>11/24/67</b>	23c NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery</b>	23d LOCATION (City or Town) (County) (State) <b>Baltimore Md.</b>
24 FUNERAL DIRECTOR <b>Howard H. Hubbard, 4107 Wilkens Ave. 21229</b>		25a REC'D BY REGISTRAR <b>NOV 24 1967</b>	
25b REGISTRAR'S SIGNATURE <b>Charles J. Jones</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and file them with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

■ A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15127

CERTIFICATE OF DEATH

15130

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>_____</b> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>		c. LENGTH OF STAY IN 1b <b>80 DAYS</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>VETERANS ADMINISTRATION HOSPITAL</b>		d. STREET ADDRESS <b>602 WASHINGTON BLVD.</b>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>LOUIS</b> Middle <b>VERNON</b> Last <b>VERNON</b>		4. DATE OF DEATH Month <b>NOVEMBER</b> Day <b>26</b> Year <b>19 67</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6 10 97</b>
9. AGE (in years last birthday) <b>70</b> yrs		f. UNDER 1 YEAR Months <b>_____</b> Days <b>_____</b>	g. UNDER 24 HRS. Hours <b>_____</b> Min <b>_____</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <b>B &amp; O RR</b>	11. BIRTHPLACE (County & State, or foreign country) <b>BALTIMORE, MARYLAND</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>FREDERICK B. VERNON</b>	
14. MOTHER'S MAIDEN NAME <b>ANNIE SMITH</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>YES WW-1</b>	
16. SOCIAL SECURITY NO. <b>705 12 6017</b>		17. INFORMANT <b>CLIN. REC., VAH, FT. HOWARD, MARYLAND</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>16-X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <b>Carcinoma, anaplastic, right lung, with metastases to cerebrum, ribs, and chest wall</b> (c) <b>_____</b>		INTERVAL BETWEEN ONSET AND DEATH <b>_____</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>_____</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <b>_____</b>		20c. TIME OF INJURY Month, Day, Year Hour <b>_____</b> a.m. <b>19</b> p.m.	
20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>_____</b>	
20f. (City or town) (County) (State) <b>_____</b>		21. I certify that (A) (this hospital) attended the deceased from <b>Sept. 7, 1967</b> to <b>Nov. 26, 1967</b> , that (A) (we) last saw the deceased alive on <b>Nov. 26, 1967</b> , and that death occurred at <b>2:00 a.m.</b> , from causes and on the date stated above.	
22a. SIGNATURE <b>George Dudas</b>		22b. DATE SIGNED <b>11 26 67</b>	
22c. PHYSICIAN'S NAME (Type) <b>GEORGE DUDAS, M.D.</b>		22d. ADDRESS <b>VA HOSPITAL FORT HOWARD, MARYLAND</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>11/29/67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Md.</b>	
24. FUNERAL DIRECTOR <b>Tickner &amp; Sons Funeral Home, North &amp; Pa St</b>		25a. REC'D BY REGISTRAR <b>NOV 29 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>William J. Judge</b>		25c. REGISTRAR'S NAME <b>William J. Judge</b>	



CERTIFICATE OF DEATH

15122

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a COUNTY <u>Baltimore</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE <u>MD.</u> b COUNTY <u>  </u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c LENGTH OF STAY IN 1b <u>30-Y</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>1021 Crosby Rd.</u>		d STREET ADDRESS <u>3048 Stafford St.</u>	
3 NAME OF DECEASED (Type or print) First Middle Last <u>Frances A. Volkman</u>		4 DATE OF DEATH Month Day Year <u>Nov. 29 1967</u>	
5 SEX <u>F</u>	6 COLOR OR RACE <u>Cauc.</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>July 28, 1904</u>
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b KIND OF BUSINESS OR INDUSTRY	9 AGE (In years past birthday) yrs <u>63</u>
11 BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13 FATHER'S NAME <u>Joseph Wieber</u>		14 MOTHER'S MAIDEN NAME <u>Henrietta</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16 SOCIAL SECURITY NO. <u>212-30-4454</u>	
17. INFORMANT <u>Mrs. John Amer</u>		Address <u>1021 Crosby Rd.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ARTERIOSCLEROTIC CARDIO</u> DUE TO <u>VASCULAR DISEASE</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u> (c) <u>  </u>			INTERVAL BETWEEN ONSET AND DEATH <u>5 YRS +</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>11/25, 1967</u> to <u>11/29, 1967</u> , that (I) (we) last saw the deceased alive on <u>11/25, 1967</u> , and that death occurred at <u>4 A.M.</u> from causes and on the date stated above.			
22a SIGNATURE <u>Thomas E. Roach</u>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <u>11/30/67</u>
22c PHYSICIAN'S NAME (Type) <u>Thomas E. Roach</u>		22d ADDRESS <u>5550 Baltimore National Pike</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b DATE THEREOF <u>12/2/67</u>	23c NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cem.</u>	23d LOCATION (City or Town) (County) (State) <u>Baltimore, Md.</u>
24 FUNERAL DIRECTOR <u>Witzke F. D. - 4101 Edmondson Ave.</u>		25a REC'D BY REGISTRAR <u>DEC 1 1967</u>	25b REGISTRAR'S SIGNATURE <u>Charles J. ...</u>





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

15129

15132

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural - Towson</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOW MD</b>			
c. LENGTH OF STAY IN ID <b>1 day</b>				d. STREET ADDRESS <b>224 PHEASANT TRAIL</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Greater Baltimore Medical Center</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Kathy</b> Middle <b>Lynn</b> Last <b>Walls</b>		4. DATE OF DEATH Month <b>Nov.</b> Day <b>29</b> Year <b>1967</b>		5. SEX <b>Female</b>		6. COLOR OR RACE <b>Cauc</b>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>8/26/66</b>		9. AGE (In years last birthday) <b>1</b> yrs. <b>3</b> Months <b>3</b> Days <b>3</b> Hours <b>3</b> Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>INFANT</b>	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>WASHINGTON COUNTY MD</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Ronald Walls</b>				14. MOTHER'S MAIDEN NAME <b>ELTON L PRICE</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>RONALD L WALLS 224 PHEASANT TRAIL</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Brain Tumor</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Nov. 27</b> , 19 <b>67</b> , to <b>Nov. 29</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>Nov. 29</b> , 19 <b>67</b> , and that death occurred at <b>4:40 M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <i>R. Breiteneker</i>				22b. DATE SIGNED <b>11/29/67</b>		22c. PHYSICIAN'S NAME (Type) <b>R. Breiteneker, M.D.</b>	
22d. ADDRESS <b>6701 N. Charles Street</b>		23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>					
23b. DATE THEREOF <b>12.1.67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>MT. OLIVET</b>		23d. LOCATION (City, town or county) <b>MD</b> (State) <b>RURAL HANCOCK WASHINGTON</b>			
24. FUNERAL DIRECTOR <i>Howard J. Shive</i>				25a. REC'D BY REGISTRAR <b>DEC 4 1967</b>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
 CERTIFICATE OF DEATH

15133

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE CO.</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE, MD.</u> c. LENGTH OF STAY IN 1b <u>2 MONTHS</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>HOUSE IN THE PINES NURSING HOME</u>		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>SYKESVILLE MD.</u> d. STREET ADDRESS <u>RT #4</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>GERTRUDE BELLE</u> First Middle Last 5. SEX <u>F</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	4. DATE OF DEATH <u>NOV. 14</u> 19 <u>67</u> Month Day Year 8. DATE OF BIRTH <u>DEC. 6, 1886</u> 80 yrs. Months Days Hours Min. 9. AGE (In years last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u> 11. BIRTHPLACE (County & State, or foreign country) <u>WESTMINSTER, CARROLL U.S.A.</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	13. FATHER'S NAME <u>WILLIAM HOOK</u> 14. MOTHER'S MAIDEN NAME <u>MARY S. REESE</u> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u> 16. SOCIAL SECURITY NO. <u>—</u> 17. INFORMANT <u>DAUGHTER - MISS LEONA WALTZ</u> Address <u>774 SYKESVILLE</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Myocardial Decompensation</u> Conditions, if any, which gave rise to immediate cause (b) <u>Generalized Arteriosclerosis</u> (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)		INTERVAL BETWEEN ONSET AND DEATH <u>2 m</u> <u>1030</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED [Enter nature of injury in Part I or Part II of item 18.] 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that (I) (this hospital) attended the deceased from <u>9-1-</u> 19 <u>67</u> , to <u>11-14</u> 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>11-13</u> 19 <u>67</u> , and that death occurred at <u>830 A</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>Wilmer K. Gallagher, Sr.</u> M.D. 22c. PHYSICIAN'S NAME (Type or print) <u>DR. WILMER K. GALLAGHER, SR.</u> 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> 23b. DATE THEREOF <u>NOV. 17, 1967</u> 23c. NAME OF CEMETERY OR CREMATORY <u>DEER PARK CEM.</u> 23d. LOCATION (City, town or county) (State) <u>SMALLWOOD MD.</u>		22b. DATE SIGNED <u>11-14-67</u> 22d. ADDRESS <u>6209 FREDERICK AVE. BALTO, MD.</u> 24. FUNERAL DIRECTOR'S SIGNATURE <u>James G. Saffell</u> ADDRESS <u>WESTMINSTER, MD.</u> 25a. REC'D BY REGISTRAR <u>NOV 16 1967</u> 25b. REGISTRAR'S SIGNATURE <u>Orlando Judge</u>	



15131

CERTIFICATE OF DEATH

15134

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Reisterstown</i>		c. LENGTH OF STAY IN 1b <i>Reisterstown</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Woodley Ave.</i>		d. STREET ADDRESS <i>Woodley Ave.</i>	
3 NAME OF DECEASED (Type or print) First <i>Darcie</i> Middle <i>M.</i> Last <i>Warner</i>		4. DATE OF DEATH Month <i>November</i> Day <i>11</i> Year <i>1967</i>	
5 SEX <i>Female</i>	6 COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <i>June 12, 1884</i>
9. AGE (In years last birthday) <i>83</i> yrs		10. IF UNDER 1 YEAR Months <i>11</i> Days <i>11</i> Hours <i>19</i> Min <i>67</i>	
10a USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) <i>Housewife</i>		10b KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (County & State, or foreign country) <i>Reisterstown, Md.</i>		12 CITIZEN OF WHAT COUNTRY? <i>US, 1</i>	
13. FATHER'S NAME <i>John Benson</i>		14. MOTHER'S MAIDEN NAME <i>Ida Gore</i>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO <i>220-48-5302</i>	
17 INFORMANT <i>Miss. Helen G. Warner</i>		Address <i>Reisterstown, Md.</i>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Cerebral arteriosclerosis</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <i>Cardio-vascular arteriosclerosis</i> (c)		INTERVAL BETWEEN ONSET AND DEATH <i>Years</i> <i>Years</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. <i>2</i> p.m. <i>19</i>		20d INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not While at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from <i>1-1-30, 19</i> to <i>11-11-1967</i> , that (I) <del>was</del> saw the deceased alive on <i>11-10-1967</i> , and that death occurred at <i>6:30</i> M, from causes and on the date stated above.			
22a SIGNATURE <i>James G. Saffell</i>		22b DATE SIGNED <i>11-11-67</i>	
22c PHYSICIAN'S NAME (Type) <i>James G. Saffell</i>		22d ADDRESS <i>Reisterstown, Md</i>	
23a BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b DATE THEREOF <i>Nov. 14, 67</i>	
23c NAME OF CEMETERY OR CREMATORY <i>Reisterstown Methodist</i>		23d LOCATION (City or Town) (County) (State) <i>Reisterstown, Md.</i>	
24 FUNERAL DIRECTOR <i>J. F. Eline &amp; Sons</i>		ADDRESS <i>Reisterstown, Md.</i>	
25a REC'D BY REGISTRAR <i>NOV 14 1967</i>		25b REGISTRAR'S SIGNATURE <i>Richard J. Judge</i>	



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>1</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>TOWSON</b>	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>12 YORK RD</b>		d. STREET ADDRESS <b>1026 N. STRICKER ST.</b>	
3. NAME OF DECEASED (Type or print) <b>ALICE STEWART WASHINGTON</b>		4. DATE OF DEATH Month <b>NOV.</b> Day <b>27</b> Year <b>67</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>C</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>2-6-1911</b>
9. AGE (in years last birthday) <b>56</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic Work</b>	
11. BIRTHPLACE (State or foreign country) <b>Davisburg, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Morton Stewart</b>		14. MOTHER'S MAIDEN NAME <b>Ellen Stewart</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO <b>215-32-0296</b>	
17. INFORMANT <b>Mrs. Susie U. Stewart</b>		Address <b>1026 Stricker</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>MYOCARDIAL INFARCTION</b> DUE TO <b>ARTERIO-SCLEROTIC CARDIOVASCULAR DISEASE</b> Conditions if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>20 YRS</b> (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>William A. Pillsbury</b> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>William A. Pillsbury</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22. DATE SIGNED <b>11-28-67</b>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, City, Town, or County) <b>Towson, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>12-2-67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>MT. HOLBURN Cem.</b>	23d. LOCATION (City or Town) (County) (State) <b>BALTO. MD.</b>
24. FUNERAL DIRECTOR <b>Morton E. Dyett F.H.</b>		ADDRESS <b>1701 Laurens St.</b>	
25a. REC'D BY REGISTRAR <b>NOV 29 1967</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VA 15-14  
2-1-67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15133

CERTIFICATE OF DEATH

16713

1 PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>6</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>		c. LENGTH OF STAY IN 1b <b>4 Wkd.</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>		30 X	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Chesapeake Manor</b>		d. STREET ADDRESS <b>Broadview Apts.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) <b>GLADYS WHITE WATERS</b>		4 DATE OF DEATH Month <b>November</b> Day <b>29</b> Year <b>1967</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 11, 1891</b>
9. AGE (In years lost birthday) <b>76</b> yrs		F UNDER 1 YEAR Months Days Hours Min IF UNDER 24 HRS	
10a. US. AL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Fidelity &amp; Deposit</b>	
11 BIRTHPLACE (County & State, or foreign country) <b>New York</b>		12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William Kingsland White</b>		14. MOTHER'S MAIDEN NAME <b>Frances Duchardt</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes give war or dates of service)		16. SOCIAL SECURITY NO <b>125-18-4616</b>	
17. INFORMANT <b>Mrs. Charles Conlon, Jr.</b>		Address <b>3742 Beech Ave.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Uremia</b> DUE TO (b) <b>Uretal obstruction</b> DUE TO (c) <b>Metastatic Ca Cervix</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost			
INTERVAL BETWEEN ONSET AND DEATH <b>Days</b> <b>Wks</b> <b>Months</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (1) this hospital attended the deceased from <b>May</b> , 19 <b>67</b> to <b>Nov</b> , 19 <b>67</b> that (2) we saw the deceased alive on <b>Nov 24 1967</b> , and that death occurred at <b>6 P</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>R. E. Gundry</b> M.D.		22b. DATE SIGNED <b>12-7-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. Richard Gundry</b>		22d. ADDRESS <b>XXXXXX XXXXXX XXXX</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Dec. 2, 1967</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Green Mount</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Md</b>	
24. FUNERAL DIRECTOR <b>Mitchell-Wiedefeld Home, Inc. 6500 York Rd. Baltimore, Md. 21212</b>		25a. REC'D BY REGISTRAR DATE <b>DEC 7 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>		c. LENGTH OF STAY IN 1b <b>14 DAYS</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>VETERANS ADMINISTRATION HOSPITAL</b>		d. STREET ADDRESS <b>14 AMITY STREET</b>	
3. NAME OF DECEASED (Type or print) First <b>JOHN</b> Middle Last <b>WATERS</b>		4. DATE OF DEATH Month <b>NOVEMBER</b> Day <b>21</b> Year <b>1967</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>NEGRO</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6/19/90</b>
9. AGE (in years last birthday) <b>77 yrs.</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LABORER</b>		12. KIND OF BUSINESS OR INDUSTRY	
13. FATHER'S NAME <b>JOHN WATERS</b>		14. MOTHER'S MAIDEN NAME <b>CAROLINE COLMAN</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>YES</b>		16. SOCIAL SECURITY NO. <b>218 09 65 17</b>	
17. INFORMANT <b>VAH</b>		18. ADDRESS <b>CLINICAL RECORDS, VAH, FT. HOWARD, MD.</b>	
19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>BRONCHOPNEUMONIA, BILATERAL</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>DAYS</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>CEREBRAL ARTERIOSCLEROSIS AND ARTERIOSCLEROTIC HEART DISEASE</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (this hospital) attended the deceased from <b>NOV 7</b> , 19 <b>67</b> , to <b>NOV 21</b> , 19 <b>67</b> , that (we) lost the deceased alive on <b>NOV 21</b> , 19 <b>67</b> , and that death occurred at <b>8:00 P.M.</b> , from causes on and on the date stated above.			
22a. SIGNATURE <b>JOHN D. TALBERT</b>		22b. DATE SIGNED <b>11/22/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>JOHN D. TALBERT, M. D.</b>		22d. ADDRESS <b>VAH FORT HOWARD, MARYLAND</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>11-27-67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>BALTIMORE NATIONAL</b>		23d. LOCATION (City or town) (County) (State) <b>BALTIMORE, MARYLAND</b>	
24. FUNERAL DIRECTOR <b>MORTEN &amp; DYETT FUNERAL HOME</b>		25a. REC'D BY REGISTRAR <b>NOV 27 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>E. LAURENS STREET, BALTIMORE, MD.</b>			

100

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VI

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH

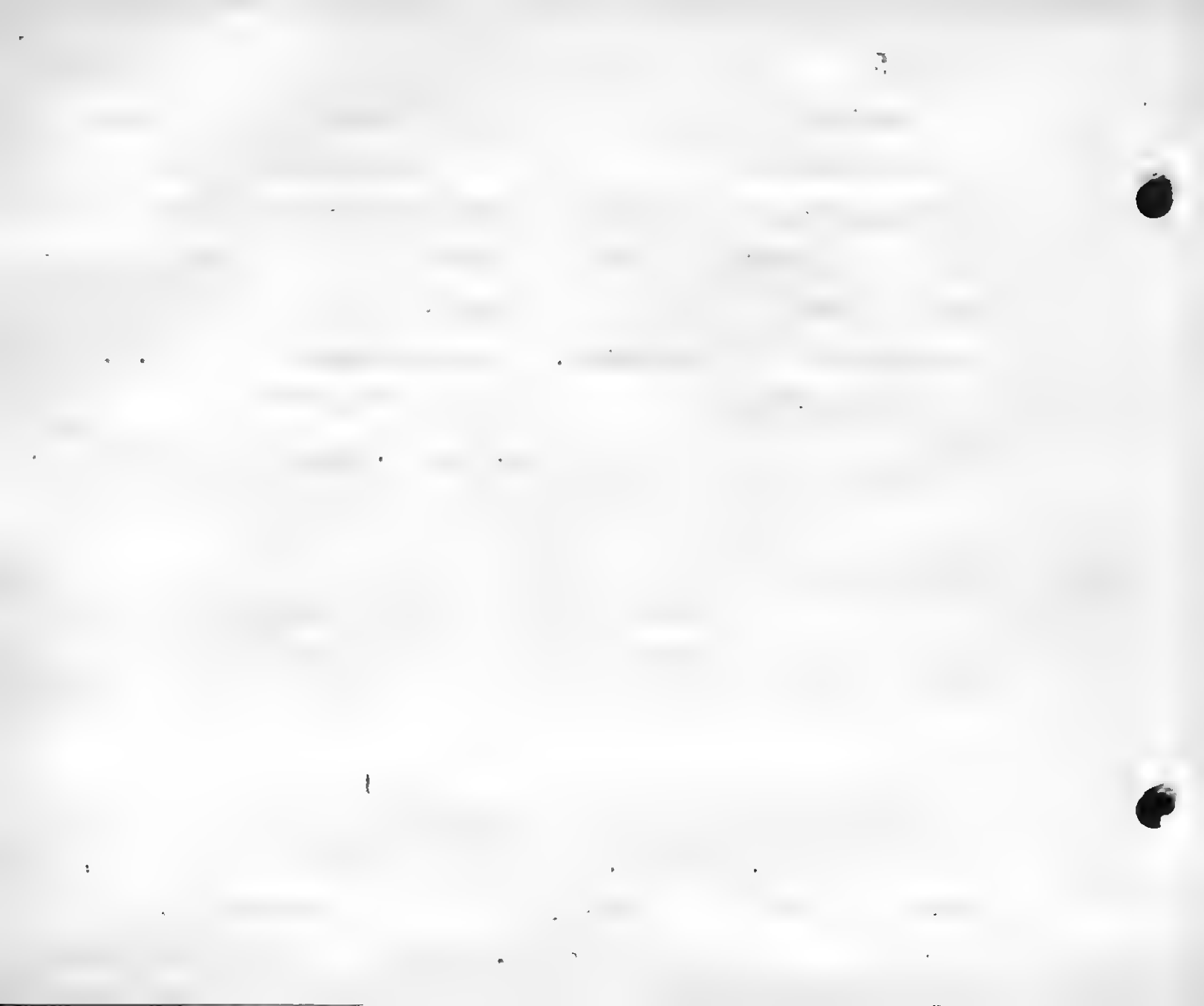
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

15135

15137

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bowleys Quarters</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bowleys Quarters</b>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>3710 Holly Grove Road 21220</b>				d. STREET ADDRESS <b>3710 Holly Grove Road 21220</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Benjamin</b> Middle <b>Milton</b> Last <b>Weikle</b>				4. DATE OF DEATH Month <b>November</b> Day <b>3</b> Year <b>1967</b>					
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 14, 1903</b>			
9. AGE (In years last birthday) <b>64</b> yrs.		IF UNDER 1 YEAR Months <b>6</b> Days <b>14</b> Hours <b>14</b> Min.		IF UNDER 24 HRS. Hours <b>14</b> Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Maintenance Man</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Chemical Co.</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Fairview Kansas</b>			
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>									
13. FATHER'S NAME <b>Benjamin Morris Weikle</b>				14. MOTHER'S MAIDEN NAME <b>Sarah Susan Wickline</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT Address <b>21220</b> <b>Mrs. Evelyn F. Weikle 3710 Holly Grove Rd.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of left lung &amp; metastases</b> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								INTERVAL BETWEEN ONSET AND DEATH <b>6 months</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) _____ (County) _____ (State) _____									
21. I certify that (I) (this hospital) attended the deceased from <b>June</b> , 19 <b>66</b> , to <b>Nov. 3</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>9/22</b> , 19 <b>67</b> , and that death occurred at <b>11 AM</b> , from the causes and on the date stated above.									
22. SIGNATURE <b>Sidney R. Gehlert</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>11/6/67</b>			
22c. PHYSICIAN'S NAME (Type) <b>Sidney R. Gehlert, M.D.</b>				22d. ADDRESS <b>4700 Pennington Ave. Balto. Md. 21226</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11/7/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill</b>		23d. LOCATION (City, town or county) (State) <b>Anne Arundel Co.</b>			
24. FUNERAL DIRECTOR <b>McCully Funeral Home</b>				ADDRESS <b>237 Patapsco Ave. 21225</b>		25a. REC'D BY REGISTRAR <b>NOV 7 1967</b>			
						25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15138

15138

FOR STATE HEALTH-DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with the death certificate. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2 USUAL RESIDENCE (where deceased lived if institution Res. dence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dundalk</b>		c. LENGTH OF STAY IN Id <b>Dundalk</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>6729 Oak Ave.</b>		d. STREET ADDRESS <b>6729 Oak Ave.</b>	
3 NAME OF DECEASED (Type or print) <b>RAY DANIEL WELCH</b>		4 DATE OF DEATH <b>Nov. 25, 19 67</b>	
5 SEX <b>Male</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>April 23, 1911</b>
9 AGE (In years lost birthday) <b>56</b> yrs		10 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min	
11 USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter-ret.</b>		12 KIND OF BUSINESS OR INDUSTRY <b>Building</b>	
13 BIRTHPLACE (State or foreign country) <b>Virginia</b>		14 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
15 FATHER'S NAME <b>Floyd H. Welch</b>		16 MOTHER'S MAIDEN NAME <b>Nellie Puckett</b>	
17 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		18 SOCIAL SECURITY NO <b>231-16-2226</b>	
19 INFORMANT <b>Floyd H. Welch</b>		Address <b>6729 Oak Ave.</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>A-S-C-V Disease</b> 4221 DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (c) _____			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTE TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			9 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of Item 18) <b>None</b>	
20c TIME OF INJURY Month, Day Year Hour a.m. p.m. <b>19</b>		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town)		(County) (State)	
21 I certify that took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>M.B. Davis</b>		DATE SIGNED <b>11/26/67</b>	
EXAMINER'S NAME Type <b>M.B. Davis, M.D.</b>		ADDRESS (Street, city, town, or county) <b>6800 Mornington Rd.</b>	
23a DATE OF BURIAL <b>Nov. 27, 1967</b>		23b NAME OF CEMETERY OR CREMATORY <b>Oak Lawn Cemetery</b>	
23c LOCATION (City, town, or county, State) <b>Colgate, Md.</b>		23d LOCATION (City, town, or county, State)	
24 FUNERAL DIRECTOR <b>Ullrich Funeral Home Dundalk, Md.</b>		25a REC'D BY REGISTRAR <b>NOV 28 1967</b>	
25b REGISTRAR'S SIGNATURE <b>Charles J. Jones</b>		25c REGISTRAR'S SIGNATURE	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15137

CERTIFICATE OF DEATH

15140

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>/</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>			c. LENGTH OF STAY IN 1b <b>/</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore, 21234</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>St. Joseph Hospital</b>				d. STREET ADDRESS <b>3514 Hiss Ave.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>LUCILLE</b> Middle <b>G.</b> Last <b>WESOLOWSKI</b>				4. DATE OF DEATH Month <b>November</b> Day <b>10</b> Year <b>19 67</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>September 9, 1912</b>		9. AGE (In years last birthday) <b>55</b> yrs	10. FINDER 1 YEAR Months <b>/</b> Days <b>/</b> Hours <b>/</b> Min <b>/</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Housewife</b>	11. BIRTHPLACE (County & State or foreign country) <b>Maryland Wilmington De.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>Charles Piotrowski</b>			14. MOTHER'S MAIDEN NAME <b>Josephine Napert</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>202-30-2652</b>	17. INFORMANT Address <b>Mr Milton J. Wesolowski 3514 Hiss Avenue</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: <b>Massive</b> <b>Intra-cerebral and Subarachnoid Hemorrhage</b> DUE TO (a) <b>/</b> (b) <b>/</b> (c) <b>/</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>/</b>						INTERVAL BETWEEN ONSET AND DEATH <b>/</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>/</b> p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f. (City or town) (County) (State)		20g. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>11/5/ 1967</b> , to <b>11/10/ 1967</b> , that (I) (we) last saw the deceased alive on <b>11/10/ 1967</b> , and that death occurred at <b>12:25M</b> , from causes and on the date stated above.							
22a. SIGNATURE <b>Reynaldo Orjuela-Gomez, M.D.</b>				22b. DATE SIGNED <b>11/10/67</b>		22c. PHYSICIAN'S NAME (Type) <b>Reynaldo Orjuela-Gomez, M.D.</b>	
22d. ADDRESS <b>7620 York Rd., Towson, Md. 21204</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>11-13-1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Holy Rosary Cemetery</b>	23d. LOCATION (City or town) (County) (State) <b>Baltimore Co. Md.</b>				
24. FUNERAL DIRECTOR <b>Lassahn Funeral Home 7401 Belair Road</b>			25a. REC'D BY REGISTRAR DATE <b>NOV 13 1967</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



## CERTIFICATE OF DEATH

15141

15132

1 PLACE OF DEATH 4303 Necker Ave. (Balto.) MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE Maryland b COUNTY Balto.	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Fullerton		c LENGTH OF STAY IN 1b 30 yrs.	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 4303 Necker Avenue		d. STREET ADDRESS 4303 Necker Avenue	
3 NAME OF DECEASED (Type or print) George J. Westerman First Middle Last		4 DATE OF DEATH Month November Day 8 Year 19 67	
5 SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 1/30/1879
9 AGE (in years and birthday) yrs 88		10 IF UNDER 1 YEAR Months Days Hours Min.	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Thick Farmer		10b KIND OF BUSINESS OR INDUSTRY Self Employed	
11 BIRTHPLACE (County & State, or foreign country) Baltimore City		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13 FATHER'S NAME Joseph Westerman		14. MOTHER'S MAIDEN NAME Margaret Dorn	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16 SOCIAL SECURITY NO. 217 09 3152	
17. INFORMANT Barbara M. Westerman		Address 4303 Necker Ave.	
18 CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Coronary Sclerosis (c) Arteriosclerosis Generalized			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE (CONDITION GIVEN IN PART I (a)) Hypertension			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Sept 11, 1967, to Nov 8, 1967, that (I) (we) lost saw the deceased alive on Nov 8, and that death occurred at 5:20 PM from causes and on the date stated above			
22a. SIGNATURE Walter A. Anderson		M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b DATE SIGNED
22c. PHYSICIAN'S NAME (Type) Dr. Walter Anderson		22d ADDRESS Shannon Drive & Belair Road 3800	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial	23b DATE THEREOF 11/11/67	23c NAME OF CEMETERY OR CREMATORY Holly Redeemer Cem.	23d LOCATION (City or Town) (County) (State) City Balto. Md.
24 FUNERAL DIRECTOR Lassahn Funeral Home 7401 Belair Road		25a REC'D BY REGISTRAR DATE NOV 13 1967	25b REGISTRAR'S SIGNATURE J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health or to burial, cremation, or removal, and in any event, within 72 hours after death.



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VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15139

15142

1 PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>				c. LENGTH OF STAY IN 1b <b>Lutherville</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>St. Joseph Hospital</b>				d. STREET ADDRESS <b>2 Westbury Road</b>			
3 NAME OF DECEASED (Type or print) First Middle Last <b>John Franklin Wheeler</b>				4 DATE OF DEATH Month Day Year <b>November 5 1967</b>			
5 SEX <b>male</b>	6 COLOR OR RACE <b>white</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1-18-1881</b>	9 AGE (In years last birthday) <b>86 yrs</b>	IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS. Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>FARMING</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore Co., Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Daniel Webster Wheeler</b>				14. MOTHER'S MAIDEN NAME <b>Mary Jane Peregoy</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <b>216-20-8355A</b>		17. INFORMANT Address <b>Lutherville</b> <b>Mrs. Estella T. Wheeler-2Westbury Rd.,</b>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Severe pulmonary edema</b> <b>7110</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) <b>Bilateral bronchopneumonia</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)					
20c. TIME OF INJURY Month Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>Nov. 2nd., 1967</b> , to <b>Nov. 5th, 1967</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>Nov. 5th 1967</b> , and that death occurred at <b>1:00AM</b> , from causes and on the date stated above.							
22a. SIGNATURE <b>Samuel Lee</b> M.D.				ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>11-5-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Samuel Lee, M.D.</b>				22d. ADDRESS <b>7620 York Road, Baltimore, Md. 21204</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Nov. 8, 1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Michael's Cem.</b>		23d. LOCATION (City or Town) (County) (State) <b>Perry Hall, Balto. Co., Md.</b>	
24. FUNERAL DIRECTOR <b>STEWART &amp; MOWEN CO. 108 W. North Av., Balto. 1</b>				25a. REC'D BY REGISTRAR DATE <b>NOV 7 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 1 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15140

CERTIFICATE OF DEATH

15143

1 PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>✓</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>		c. LENGTH OF STAY IN TB <b>26 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Veterans Administration Hospital</b>		e. STREET ADDRESS <b>605 Pontiac Avenue</b>	
3 NAME OF DECEASED (Type or print) First <b>THOMAS</b> Middle <b>C</b> Last <b>WIEST</b>		4 DATE OF DEATH Month <b>November</b> Day <b>6</b> Year <b>19 67</b>	
5. SEX <b>Male</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>December 15, 1910</b>
9. AGE (In years and months) <b>56 yrs.</b>		10. IF UNDER 1 YEAR Months <b>56</b> Days <b>0</b> Hours <b>0</b> Min <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Guard</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Security</b>	
11 BIRTHPLACE (County & State, or foreign country) <b>Baltimore, Md.</b>		12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Milton Wiest</b>		14. MOTHER'S MAIDEN NAME <b>Elsie Keeney</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes WW-11</b>		16 SOCIAL SECURITY NO. <b>226 03 93 53</b>	
17 INFORMANT <b>Clinical Recds, VA Hospital, Fort Howard Md.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARCINOMA OF KIDNEY WITH METASTASES</b> DUE TO (b) <b>180x</b> DUE TO (c) <b>Unk.</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part I of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)	
21. I certify that (X) (this hospital) attended the deceased from <b>Oct. 11</b> , 19 <b>67</b> , to <b>Nov. 6</b> , 19 <b>67</b> that (X) (we) lost saw the deceased alive on <b>Nov. 6</b> , 19 <b>67</b> , and that death occurred at <b>5:50M</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>J. D. Talbert</b>		22b. DATE SIGNED <b>11/6/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>JOHN D. TALBERT, M.D.</b>		22d. ADDRESS <b>VA Hospital, Fort Howard, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11-9-1967</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Loudon National Cem., Baltimore, Maryland</b>		23d. LOCATION (City or Town) (County) (State)	
24 FUNERAL DIRECTOR <b>George J. Gonce</b>		25a. REC'D BY REGISTRAR <b>Ritchie Hwy</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		DATE <b>NOV 10 1967</b>	

GEORGE GONCE FUNERAL HOME

Baltimore, Md.





1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
5141  
CERTIFICATE OF DEATH

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Baltimore</u> <u>MARYLAND</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Towson</u> c. LENGTH OF STAY in 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Armacost Nursing Home</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>313 E. Lake Avenue</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF</b> (Type or print) <u>Marjorie L. Wilhelm</u> First Middle Last <b>5. SEX</b> <u>Female</u> <b>6. COLOR OR RACE</b> <u>White</u> <b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>Feb. 12, 1902</u> <b>9. AGE</b> (In years last birthday) <u>65</u> yrs. <b>IF UNDER 1 YEAR</b> Months Days <b>IF UNDER 24 HRS.</b> Hours Min.		<b>4. DATE OF DEATH</b> <u>Nov. 4, 1967</u> <u>19</u> <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Clerk</u> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>--</u> <b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Baltimore, Md.</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>	
<b>13. FATHER'S NAME</b> <u>John H. Wilhelm</u> <b>14. MOTHER'S MAIDEN NAME</b> <u>Laura R. Hammel</u>		<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u> <b>16. SOCIAL SECURITY NO.</b> <u>215-10-8892</u> <b>17. INFORMANT</b> <u>Edwin H. Wilhelm (Brother)</u> <u>Same</u> Address	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a) (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL HEMORRHAGE</u> DUE TO (b) <u>METASTASIS from</u> DUE TO (c) <u>CARCINOMA OF BREAST</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>NONE</u>		<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>10 days</u> <u>1 year</u> <u>1 year</u> <b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18) <u>NONE</u> <b>20c. TIME OF INJURY</b> Month, Day, Year <u>19</u> Hour a.m. p.m. <b>20d. INJURY OCCURRED</b> While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town)</b> (County) (State)		<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>Oct 31, 1967</u> <b>to</b> <u>Nov 4, 1967</u> <b>that (I) (we) last saw the deceased alive on</b> <u>Oct 31, 1967</u> , <b>and that death occurred at</b> <u>4:30 PM</u> , <b>from the causes and on the date stated above.</b>	
<b>22a. SIGNATURE</b> <u>A. S. Chalfant</u> <b>22c. PHYSICIAN'S NAME</b> (Type) <u>A. S. Chalfant</u>		<b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/> <b>22d. ADDRESS</b> <u>6210 York Road</u> <b>22b. DATE SIGNED</b> <u>Nov. 6, 1967</u>	
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u> <b>23b. DATE THEREOF</b> <u>Nov 7, 1967</u> <b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Parkwood Cemetery</u> <b>23d. LOCATION</b> (City, town or county) (State) <u>Balto. Maryland</u>		<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Eugenia F. Seitz</u> <u>5209 York Rd.</u> <u>Seitz Funeral Home</u> <u>Balto. Md. 21212</u> <b>25a. REC'D BY REGISTRAR</b> <u>NOV 7 1967</u> <b>25b. REGISTRAR'S SIGNATURE</b> <u>Charles Judge</u>	



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15145

1 PLACE OF DEATH a COUNTY <b>Baltimore</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE <b>Maryland</b> b COUNTY <b>Baltimore</b>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c LENGTH OF STAY IN 1b <b>Baltimore</b>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>House of the Pines Nursing Home</b>		d STREET ADDRESS <b>492 Brunswick Street</b>	
3 NAME OF DECEASED (Type or print) <b>MARY M. WILLHAUCK</b>		4 DATE OF DEATH Month <b>November</b> Day <b>30</b> Year <b>19 67</b>	
5 SEX <b>Female</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>11-6-1873</b>
9 AGE (in years last birthday) yrs <b>94</b>		10 IF UNDER 1 YEAR Months <b>1</b> Days <b>15</b> Hours <b>27</b> Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (County & State, or foreign country) <b>Baltimore, Maryland</b>		12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Henry Funkmann</b>		14 MOTHER'S MAIDEN NAME <b>Verna</b>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16 SOCIAL SECURITY NO	
17 INFORMANT <b>Mrs. Sophia D. McCammon, 492 Brunswick St.</b>		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Myocardial Ischemia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Cardio-Vascular Disease</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <b>1 mo 15 dy</b>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes Mellitus</b>			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>8-5-</b> , 1958, to <b>11-30</b> , 1967, that (I) (we) last saw the deceased alive on <b>11-29-</b> 1967, and that death occurred at <b>4:30 A.M.</b> from causes and on the date stated above.			
22a SIGNATURE <b>Wilmer K. Gallagher</b>		22b. DATE SIGNED <b>12/1/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. Wilmer K. Gallagher</b>		22d. ADDRESS <b>6209 Frederick Ave., Catonsville, Md.</b>	
23a BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b DATE THEREOF <b>12-4-1967</b>	23c NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery</b>	23d LOCATION (City or Town) (County) (State) <b>Baltimore, Maryland</b>
24 FUNERAL DIRECTOR <b>Howard H. Hubbard, 4107 Wilkens Ave.</b>		25a REC'D BY REGISTRAR <b>DEC 6 1967</b>	25b REGISTRAR'S SIGNATURE <b>Charles Judge</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, (Pages 1 and 2) should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MARYLAND STATE DEPARTMENT OF HEALTH

# CERTIFICATE OF DEATH

15143

15146

1 PLACE OF DEATH a COUNTY <u>Baltimore</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE <u>Maryland</u> b COUNTY <u>Howard</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Randallstown</u>		c LENGTH OF STAY in 1b <u>2 days</u>	
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mariottsville, Maryland</u>		d STREET ADDRESS	
a NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Baltimore County General H</u>		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>L.</u> Last <u>Williams</u>		4 DATE OF DEATH Month <u>11</u> Day <u>11</u> Year <u>1967</u>	
5 SEX <u>m</u>	6 COLOR OR RACE <u>Negro</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>6-10-01</u>
9 AGE (In years last birthday) <u>66</u> yrs		10 IF UNDER 1 YEAR Months <u>11</u> Days <u>11</u> Hours <u>19</u> Min.	
10a USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer</u>		10b KIND OF BUSINESS OR IND. STRY <u>Agriculture</u>	
11 BIRTHPLACE (County & State for foreign country) <u>Md.</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13 FATHER'S NAME <u>Wallace R. Williams</u>		14 MOTHER'S MAIDEN NAME <u>Kaura J. Harrison</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16 SOCIAL SECURITY NO. <u>219-07-2588</u>	
17 INFORMANT <u>Mrs. Maria Beatrice Williams wife of John</u>		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Brain Metastasis</u> DUE TO <u>Primary of the Stomach</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Primary of the Stomach</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>11-10</u> , 19 <u>67</u> , to <u>11-11</u> , 19 <u>67</u> ; that (I) (we) last saw the deceased alive on <u>11-10</u> , 19 <u>67</u> , and that death occurred at <u>2:45</u> A.M., from causes and on the date stated above.			
22a SIGNATURE <u>Josue P. Laredo</u>		22b. DATE SIGNED <u>11-11-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>JOSUE P. LAREDO</u>		22d. ADDRESS <u>BALTO. COUNTY GEN. HOSP.</u>	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b DATE THEREOF <u>11-14-67</u>	
23c NAME OF CEMETERY OR CREMATORY <u>West Liberty</u>		23d LOCATION (City or Town) (County) (State) <u>Alpha, Howard Co. Md.</u>	
24. FUNERAL DIRECTOR <u>Arthur H. Haight</u>		25a. REC'D BY REGISTRAR <u>Shelbyville, Md.</u>	
25b. REGISTRAR'S SIGNATURE <u>Shelbyville, Md.</u>		DATE <u>NOV 16 1967</u>	

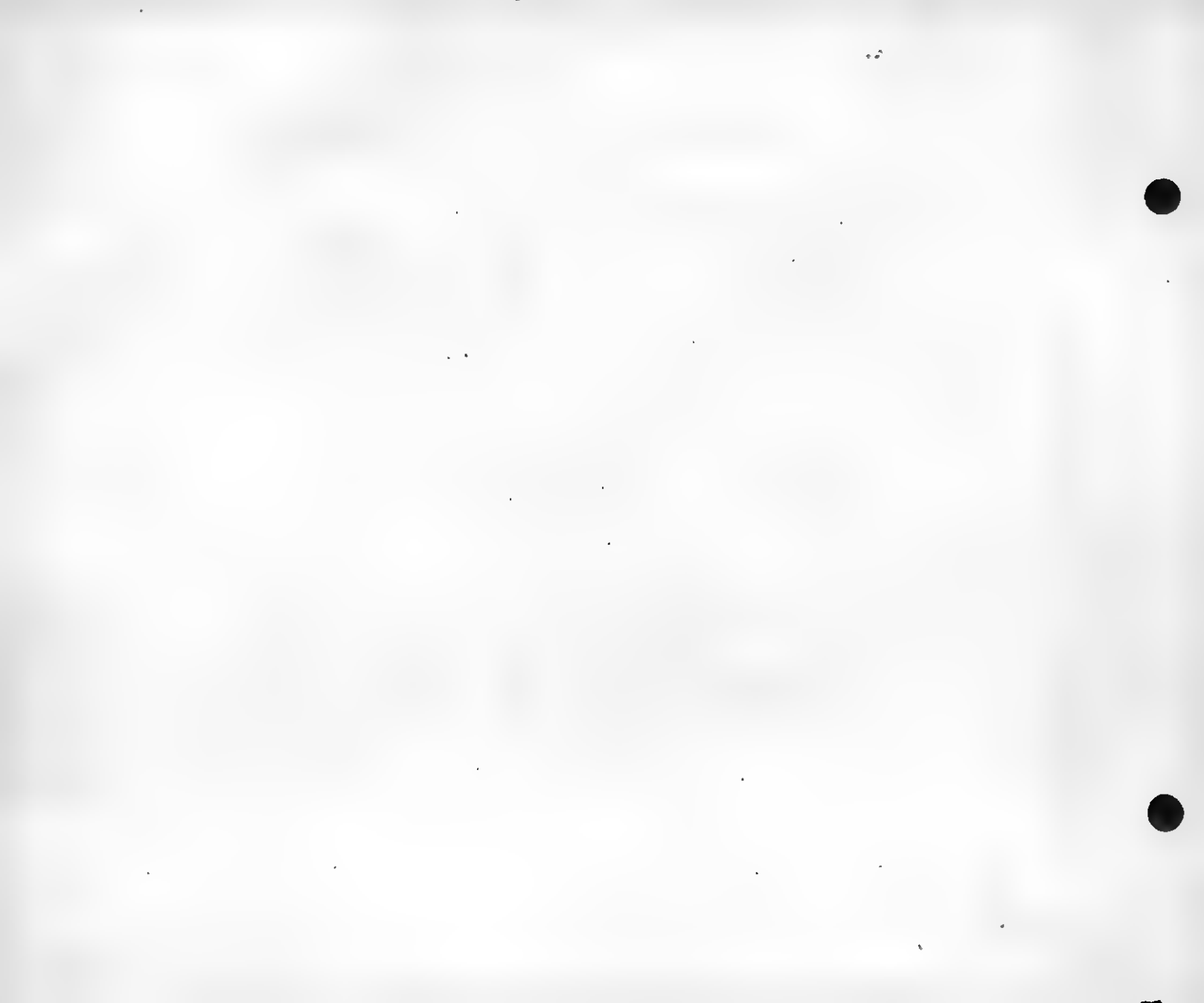


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

<div style="text-align: center;"> <b>MARYLAND STATE DEPARTMENT OF HEALTH</b>  <b>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</b>  <b>CERTIFICATE OF DEATH</b> </div>											
<b>1. PLACE OF DEATH</b> <b>a. COUNTY</b> <u>Baltimore</u> <b>MARYLAND</b> <b>b. CITY OR TOWN</b> (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u> <b>c. LENGTH OF STAY IN 1b</b> <u>19 days</u> <b>d. NAME OF HOSPITAL OR INSTITUTION</b> (If not in hospital, give street address) <u>Greater Baltimore Medical Center</u>					<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) <b>a. STATE</b> <u>Maryland</u> <b>b. COUNTY</b> <u>City</u> <b>c. CITY OR TOWN</b> (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> <b>d. STREET ADDRESS</b> <u>603 Glenolden Ave.</u> <b>e. IS RESIDENCE ON A FARM?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
<b>3. NAME OF DECEASED</b> (Type or print) <u>Sandra</u> <b>5. SEX</b> <u>F</u>			<b>6. COLOR OR RACE</b> <u>Negro</u>		<b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>Jan 6, 1961</u>		<b>9. AGE</b> (In years last birthday) <u>6</u> yrs. <b>IF UNDER 1 YEAR</b> Months <u>4</u> Days <u>19</u> Hours <u>67</u> Min.		
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Na</u>			<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Na</u>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Baltimore, Md.</u>			<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>			
<b>13. FATHER'S NAME</b> <u>James Williams</u>					<b>14. MOTHER'S MAIDEN NAME</b> <u>Na</u>						
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u>			<b>16. SOCIAL SECURITY NO.</b> <u>Na</u>		<b>17. INFORMANT</b> <u>James Williams 603 Glenolden Ave</u>						
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] <b>PART I. DEATH WAS CAUSED BY:</b> <b>IMMEDIATE CAUSE (a)</b> <u>Cerebral edema, severe</u> <b>CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST.</b> <b>DUE TO (b)</b> <u>glomerulonephritis (?)</u> <b>DUE TO (c)</b> <u>Na</u>										<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>										<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b> <input type="checkbox"/>			<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)								
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <u>19</u>			<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)				
<b>21. I certify that</b> <u>Dr</u> (this hospital) <u>attended the deceased from 10/17, 1967, to 11/4, 1967, that (we) last saw the deceased alive on 11/4, 1967, and that death occurred at 7:42 PM, from the causes and on the date stated above.</u>											
<b>22a. SIGNATURE</b> <u>Michael T. Bernstein</u> <b>M.D.</b> <b>ATTENDING PHYS.</b> <input type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input checked="" type="checkbox"/>										<b>22b. DATE SIGNED</b> <u>11/4/67</u>	
<b>22c. PHYSICIAN'S NAME (Type)</b> <u>Michael T. Bernstein</u>					<b>22d. ADDRESS</b> <u>1620 McElderry Street</u>						
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Buried</u>			<b>23b. DATE THEREOF</b> <u>11/8/1967</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>MT AUBURN</u>			<b>23d. LOCATION (City, town or county)</b> (State) <u>BALTO MD</u>			
<b>24. FUNERAL DIRECTOR</b> <u>Marjorie A. Hays</u> <b>ADDRESS</b> <u>638 N. Gilmor St</u>					<b>25a. REC'D BY REGISTRAR</b> <u>NOV 8 1967</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>Charles Judge</u>				





# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15145

## CERTIFICATE OF DEATH

15148

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<b>1 PLACE OF DEATH</b> a. COUNTY <b>Baltimore</b> MARYLAND				<b>2 USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Balto.</b>									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Owings Mills</b>			c. LENGTH OF STAY IN TB <b>5 months</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Rosewood State Hospital</b>						d. STREET ADDRESS <b>2408 Lamport Lane</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
<b>3 NAME OF DECEASED</b> (Type or print) First Middle Last <b>Lisa Marie WILLIAMSON</b>				<b>4 DATE OF DEATH</b> Month Day Year <b>11 8 19 67</b>									
<b>5 SEX</b> <b>Female</b>		<b>6 COLOR OR RACE</b> <b>White</b>		<b>7 MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8 DATE OF BIRTH</b> <b>1-19-64</b>		<b>9 AGE</b> (n years last birthday) yrs <b>3</b>		<b>10 UNDER 1 YEAR</b> Months Days <b>11</b> <b>8</b>		<b>11 UNDER 24 HRS</b> Hours Min <b>19 67</b>	
<b>10a USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Dependent</b>				<b>10b KIND OF BUSINESS OR INDUSTRY</b> <b>none</b>		<b>11. BIRTHPLACE</b> (County & State or foreign country) <b>Baltimore City, Md.</b>				<b>12 CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>			
<b>13 FATHER'S NAME</b> <b>Reese Franklin Williamson</b>						<b>14. MOTHER'S MAIDEN NAME</b> <b>Loretta Irene Forrest</b>							
<b>15 WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give war or dates of service) <b>no --</b>				<b>16 SOCIAL SECURITY NO</b> <b>none</b>		<b>17 INFORMANT</b> Address <b>Rosewood Records, Owings, Mills, Maryland</b>							
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Bilateral Orthostatic Pneumonia</b> <b>1531</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Congenital brain deformity</b> DUE TO (c)										INTERVA. BETWEEN ONSET AND DEATH <b>3 wks</b> <b>3 yr 6 months</b>			
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)</b>												<b>19 WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)									
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <b>19</b>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)					
<b>21 I certify that (X) (this hospital) attended the deceased from 5/18, 1967, to 11/8, 1967 that (X) (we) last saw the deceased alive on 11/8, 1967, and that death occurred at 1 p.m., from causes and on the date stated above.</b>													
<b>22a. SIGNATURE</b> <i>Richard A. Jones</i>						<b>ATTENDING PHYS.</b> <input type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input checked="" type="checkbox"/>		<b>22b. DATE SIGNED</b> <b>11-9-67</b>					
<b>22c. PHYSICIAN'S NAME (Type)</b> <b>Richard A. Jones, M.D.</b>						<b>22d. ADDRESS</b> <b>Rosewood St. Hosp., Owings Mills, Md.</b>							
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>BURIAL</b>			<b>23b. DATE THEREOF</b> <b>NOV 11 1967</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>OAK LAWN CEM.</b>			<b>23d. LOCATION (City or Town) (County) (State)</b> <b>EASTERN AVE BALTO. MD</b>					
<b>24. FUNERAL DIRECTOR</b> ADDRESS <b>DIPPEL BRUS INC. THE BELAIR RD</b>						<b>25a. RECD BY REGISTRAR</b> <b>NOV 13 1967</b>		<b>25b. REGISTRAR'S SIGNATURE</b> <i>Charles Judge</i>					



# FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

15146		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		15149	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH					
1 PLACE OF DEATH a COUNTY <u>Baltimore</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE <u>Md</u> b COUNTY <u>Baltimore</u>			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>		c LENGTH OF STAY in lb		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Balto</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>St Joseph Hospital</u>		d STREET ADDRESS <u>2621 Huntington Ave</u>		e RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <u>Mamie R. Wills</u>		4 DATE OF DEATH Month <u>11</u> Day <u>15</u> Year <u>1967</u>			
5. SEX <u>Female</u> 6 CO. OR RACE <u>White</u>		7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH <u>Sept 3 1883</u>	
9 AGE (in years last birthday) <u>84</u> yrs		10 UNDER 1 YEAR Months <u>11</u> Days <u>15</u> Hours <u>19</u> Min <u>67</u>		11 UNDER 24 HRS Months <u>11</u> Days <u>15</u> Hours <u>19</u> Min <u>67</u>	
10a US. AL OCCUPATION (Give kind of work done during most of working life even if retired) <u>At Home</u>		10b KIND OF BUSINESS OR INDUSTRY <u>-</u>		11 BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12 CITIZEN OF WHAT COUNTRY? <u>USA</u>		13 FATHER'S NAME <u>David G Butcher</u>		14 MOTHER'S MAIDEN NAME <u>Dorcas Virginia Lee</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>220 48 8218</u>		16 SOCIAL SECURITY NO <u>220 48 8218</u>		17 INFORMANT <u>George D. Wills</u> Address <u>2808 N Howard St</u>	
18 CAUSE OF DEATH (Enter on any one cause per line for (a), (b) and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> DUE TO (b) <u>Bronchial Pneumonia</u> DUE TO (c) <u>Fracture of Rt Hip</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 Day</u> <u>1 wk</u> <u>6 wks</u>			
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part or Part I of item 18) <u>Fallen Home</u>			
20c TIME OF INJURY Month Day, Year <u>410</u> Hour <u>pm</u> <u>October 6 1967</u>		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work or work		20e PLACE OF INJURY (Home farm factory street office bldg etc) <u>Home</u>	
20f (City or town) <u>Baltimore City Md</u>		(County) <u>Md</u>		(State) <u>Md</u>	
21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspect on <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED <u>11/16/67</u>	
ACTUAL SIGNATURE <u>Charles F. O'Donnell</u> M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Charles F. O'Donnell, M.D.</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (Street city, town or county) <u>11/16/67</u>	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b DATE THEREOF <u>11-20-67</u>		23c NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cem</u>	
23d LOCATION (City or town) <u>Woodlawn Baltimore Md</u>		(County) <u>Md</u>		(State) <u>Md</u>	
24 FUNERAL DIRECTOR <u>Burgee Fynerd Home 3631 Falls Rd</u>		25a REC'D BY REGISTRAR <u>DANDV 21 1967</u>		25b REGISTRAR'S SIGNATURE <u>James J. Jones</u>	



## CERTIFICATE OF DEATH

15150

1 PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Balto.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Glyndon</i>		c. LENGTH OF STAY IN 1b <i>Glyndon</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>19 Chatsworth Ave.</i>		d. STREET ADDRESS <i>19 Chatsworth Ave.</i>	
3 NAME OF DECEASED (Type or print) <i>Andrew S. Wilson</i>		4. DATE OF DEATH Month <i>November</i> Day <i>19</i> Year <i>1967</i>	
5 SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Oct. 17, 1880</i>
9. AGE (in years last birthday) <i>87</i> yrs		10. IF UNDER 1 YEAR Months <i>0</i> Days <i>0</i> Hours <i>0</i> Min <i>0</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired Farmer</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (County & State, or foreign country) <i>Balto. Co. Md.</i>		12 CITIZEN OF WHAT COUNTRY <i>USA</i>	
13. FATHER'S NAME <i>James Wilson</i>		14. MOTHER'S MAIDEN NAME <i>Mary Allender</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No</i>		16 SOCIAL SECURITY NO <i>213-36-8199</i>	
17 INFORMANT <i>Mr. S. Yeatts Wilson</i>		Address <i>Glyndon, Md.</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Gangrene right foot &amp; leg</i> DUE TO (b) <i>Generalized Arteriosclerosis</i> DUE TO (c) <i>10 yrs.</i>			INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>none</i>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MED. CAL. EXAMINER) <i>none</i>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>none</i> p.m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) ( <del>we</del> ) attended the deceased from <i>7-11-38</i> , 19__ to <i>11-19-67</i> , 19__, that (I) ( <del>we</del> ) saw the deceased alive on <i>11-19-67</i> , 19__, and that death occurred at <i>4 P</i> M, from causes and on the date stated above.			
22a. SIGNATURE <i>D.D. Caples</i>		22b. DATE SIGNED <i>11-20-67</i>	
22c. PHYSICIAN'S NAME (Type) <i>D. D. Caples, M. D.</i>		22d. ADDRESS <i>6 Hanover Rd., Reisterstown, Md. 21136</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE THEREOF <i>Nov. 22, 67</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Reisterstown Methodist</i>	23d. LOCATION (City or Town) (County) (State) <i>Reisterstown, Md.</i>
24. FUNERAL DIRECTOR <i>J. F. Eline &amp; Sons</i>		ADDRESS <i>Reisterstown, Md.</i>	
25a. REC'D BY REGISTRAR <i>NOV 21 1967</i>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15148

15151

1. PLACE OF DEATH a COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institut on Residence before adm ssion) a STATE <b>MARYLAND</b> b COUNTY	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>		c LENGTH OF STAY IN 1b <b>107 DAYS</b>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>VETERANS ADMINISTRATION HOSPITAL</b>		d STREET ADDRESS <b>1619 DRUID HILL AVENUE</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>SOLOMON MERRIMAN WILSON</b>		4. DATE OF DEATH Month Day Year <b>NOVEMBER 22 19 67</b>	
5 SEX <b>MALE</b>	6. COLOR OR RACE <b>NEGRO</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>3/9/90</b>
9. AGE (In years last birthday) yrs <b>77</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>WAITER</b>	
10b. KIND OF BUSINESS OR INDUSTRY <b>HOTEL</b>		11. BIRTHPLACE (County & State, or foreign country) <b>CENTERVILLE, MARYLAND</b>	
13. FATHER'S NAME <b>SOLOMON WILSON</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>YES WWI</b>		14. MOTHER'S MAIDEN NAME <b>DOLLIE ROZIER</b>	
16. SOCIAL SECURITY NO <b>219 01 91 15</b>		17. INFORMANT <b>CLINICAL RECORDS, VAH, FT. HOWARD, MD.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO <b>CEREBRAL VASCULAR ACCIDENT</b> (b) <b>CEREBRAL ARTERIOSCLEROSIS</b> (c) <b>UNKNOWN</b>			INTERVAL BETWEEN CAUSE AND DEATH <b>HOURS</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE COND.TION G.VEN IN PART I(a) <b>ASHD AND ACVD</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (this hospital) attended the deceased from <b>AUG 7, 19 67</b> , to <b>NOV 22, 19 67</b> , that (we) lost saw the deceased alive on <b>NOV 22, 19 67</b> , and that death occurred at <b>7:15 PM</b> , from causes and on the date stated above			
22a. SIGNATURE <i>[Signature]</i>		22b. DATE SIGNED <b>11/22/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>RODOLFO G. MIRO</b>		22d. ADDRESS <b>VAH, FT. HOWARD, MD.</b>	
23a. BURIAL, CREMAT, OR REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>11-27-67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Balto. National Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Maryland</b>
24. FUNERAL DIRECTOR <b>Morton &amp; Dyett Funeral Home</b>		25a. REC'D BY REGISTRAR <b>1701-31 Laurens St</b>	25b. REGISTRAR'S SIGNATURE <b>DATE NOV 27 1967</b>





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers - Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 M  
20 M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

# CERTIFICATE OF DEATH

15142

15152

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>TOWSON</b>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>ST. JOSEPH HOSPITAL</b>				d. STREET ADDRESS <b>307 TUNBRIDGE RD. #2212</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>E.</b> Middle <b>STUART</b> Last <b>WINDSOR</b>				4. DATE OF DEATH Month <b>NOVEMBER</b> Day <b>2</b> Year <b>1967</b>			
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>October 11, 1900</b>		9. AGE (In years last birthday) <b>67</b> yrs	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SELF EMPLOYED</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>INSURANCE</b>		11. BIRTHPLACE (County & State or foreign country) <b>BALTIMORE, MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Edmund S. Windsor</b>				14. MOTHER'S MAIDEN NAME <b>May Ward</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>yes W.W.II USCG reserve</b>		16. SOCIAL SECURITY NO. <b>213-05-6851</b>		17. INFORMANT Address <b>Gordon A. Gaumitz 2 W. Melrose Ave. #21212</b>			
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> <b>4201</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>4 Hours</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>November 2, 1967</b> , to <b>November 2, 1967</b> , that (I) (we) last saw the deceased alive on <b>November 2, 1967</b> , and that death occurred at <b>5:33 AM</b> from causes and on the date stated above.							
22a. SIGNATURE <b>Sylvan D. Goldberg</b>				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22b. DATE SIGNED <b>November 2, 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>Sylvan D. Goldberg, M.D.</b>				22d. ADDRESS <b>Medical Arts Building Balto., Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11/4/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Druid Ridge</b>		23d. LOCATION (City or Town) (County) (State) <b>Balto. County, Md.</b>	
24. FUNERAL DIRECTOR ADDRESS <b>Mitchell-Wiedefeld Home 6500 York Rd. Balto., Md. 21212</b>				25a. REC'D BY REGISTRAR DATE <b>NOV 3 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

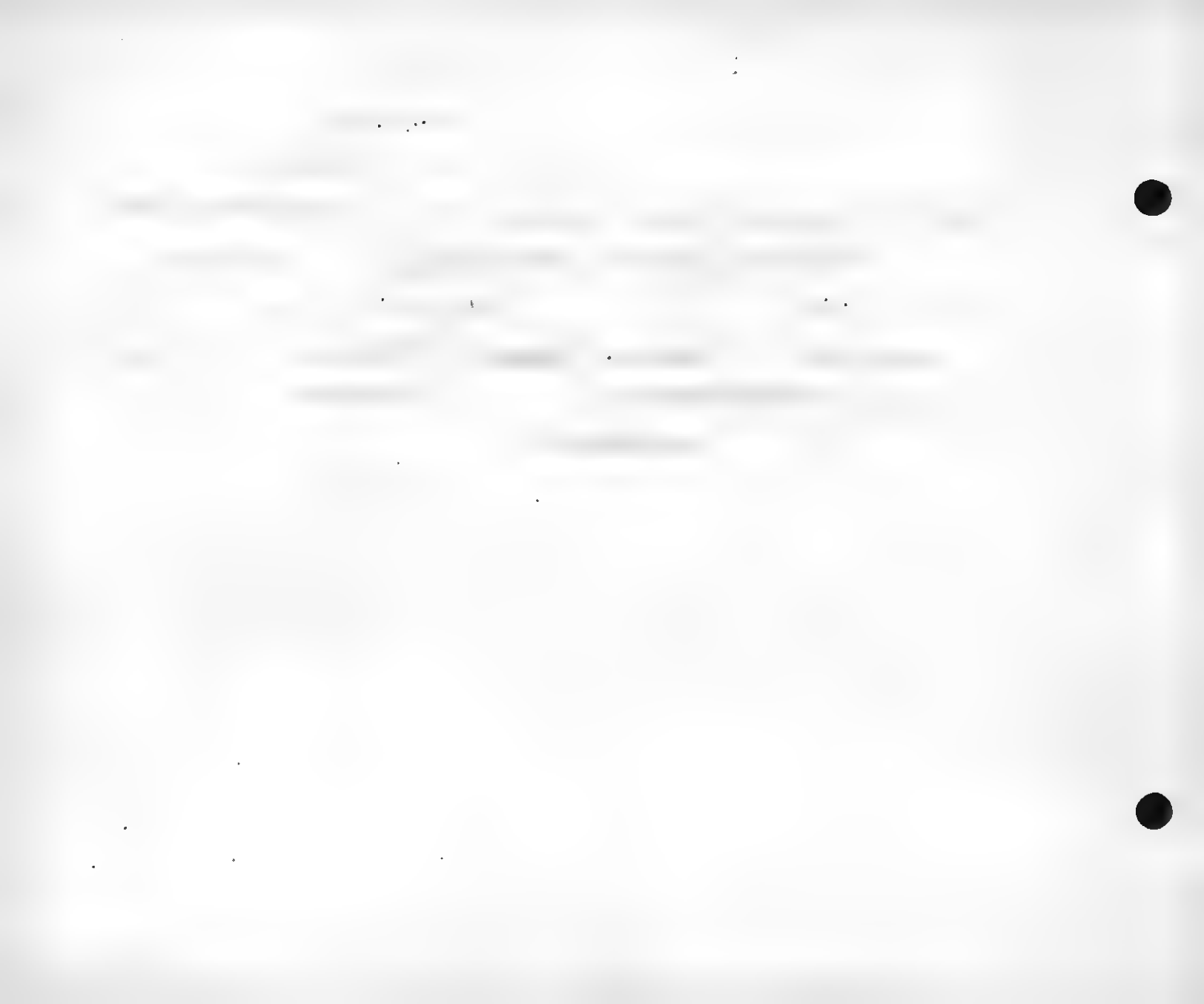


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

<div style="text-align: center;"> <b>MARYLAND STATE DEPARTMENT OF HEALTH</b>  <b>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</b>  <b>CERTIFICATE OF DEATH</b> </div>									
<b>1. PLACE OF DEATH</b> a. COUNTY <b>BALTIMORE</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>TOWSON - 21204</b> c. LENGTH OF STAY IN 1b <b>26 DAYS</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>GREATER BALTIMORE MEDICAL CENTER</b>					<b>2. USUAL RESIDENCE</b> (Where deceased lived, If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b> d. STREET ADDRESS <b>601 S. MONTFORD AVE</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
<b>3. NAME OF DECEASED</b> (Type or print) <b>WALTER JOSEPH WISNIEWSKI</b> First Middle Last <b>4. DATE OF DEATH</b> <b>NOVEMBER 15 1967</b> Month Day Year					<b>5. SEX</b> <b>M</b> <b>6. COLOR OR RACE</b> <b>CAU.</b> <b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <b>01-07-92</b> <b>9. AGE</b> (In years last birthday) <b>75</b> yrs. IF UNDER 1 YEAR: Months Days Hours Min.				
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>GROCERY-</b> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>GROCERY- RETIRED</b> <b>11. BIRTH PLACE</b> (County & State, or foreign country) <b>POLAND</b> <b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA.</b>					<b>13. FATHER'S NAME</b> <b>JOSEPH WISNIEWSKI</b> <b>14. MOTHER'S MAIDEN NAME</b> <b>UNKNOWN</b>				
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <input type="checkbox"/> <b>16. SOCIAL SECURITY NO.</b> <b>214-34-2649</b> <b>17. INFORMANT</b> Address					<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiorespiratory failure</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Acute myeloid leukemia</b> DUE TO (c) <b>Chronic myeloid leukemia</b> DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, notify medical examiner) <input type="checkbox"/> <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of Item 18.)				
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <b>19</b>					<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town) (County) (State)</b>				
<b>21. I certify that (I) (this hospital) attended the deceased from 10-21, 1963 to 11-15, 1967, that (I) (we) last saw the deceased alive on 11-15, 1967, and that death occurred at 7:15 PM, from the causes and on the date stated above.</b>									
<b>22a. SIGNATURE</b> <b>MANUEL V. GATCH</b> <b>22c. PHYSICIAN'S NAME (Type)</b> <b>MANUEL V. GATCH</b> <b>22d. ADDRESS</b> <b>Greater Baltimore Med Ctr</b>					<b>22b. DATE SIGNED</b> <b>11-15-67</b> <b>22e. MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input checked="" type="checkbox"/>				
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>BURIAL</b> <b>23b. DATE THEREOF</b> <b>11/20/67</b> <b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>HOLY ROSARY CEMETERY</b> <b>23d. LOCATION (City, town or county) (State)</b> <b>MD</b>					<b>24. FUNERAL DIRECTOR</b> <b>JOHN M. WEBER &amp; SONS INC.</b> <b>25a. REC'D BY REGISTRAR</b> <b>NOV 17 1967</b> <b>25b. REGISTRAR'S SIGNATURE</b> <b>John M. Weber</b>				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15151

15154

1 PLACE OF DEATH a COUNTY <b>Baltimore</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a STATE <b>Maryland</b> b COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
c LENGTH OF STAY IN b <b>15 days</b>		d STREET ADDRESS <b>36 South Carey St.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>SPRING GROVE STATE HOSPITAL</b>		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First <b>Walter</b> Middle Last <b>Witherspoon</b>		4 DATE OF DEATH Month <b>November</b> Day <b>8</b> Year <b>67</b>	
5. SEX <b>male</b>	6 COLOR OR RACE <b>white</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>Feb. 2, 1880</b>
9 AGE (In years, months, days) <b>87</b> yrs		IF UNDER 1 YEAR Months Days Hours Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>unknown</b>		10b KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>Virginia</b>		12 CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
13 FATHER'S NAME		14 MOTHER'S MAIDEN NAME	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17 INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial infarction, acute</b> DUE TO (b) <b>Arteriosclerotic Cardiovascular Ht. Dis.</b> DUE TO (c) <b>Arteriosclerosis, generalized, senile.</b>			
INTERVAL BETWEEN ONSET AND DEATH <b>1 hour</b>			
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic Brain Syndrome associated with I c. above.</b>			
19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)		20f (City or town) (County) (State)	
21. I certify that (this hospital) attended the deceased from <b>Oct. 23, 1967</b> to <b>Nov. 8, 1967</b> , that (we) last saw the deceased alive on <b>Nov. 8, 1967</b> , and that death occurred at <b>9:35 A.M.</b> from causes and on the date stated above.			
22a SIGNATURE <b>Anthony J. Young, M.D.</b>		22b DATE SIGNED <b>11-8-67</b>	
22c PHYSICIAN'S NAME (Type) <b>Anthony J. Young, M.D.</b>		22d ADDRESS <b>SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228</b>	
23a BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>		23b DATE THEREOF <b>11/21/67</b>	
23c NAME OF CEMETERY OR CREMATORY <b>U. of Med. School</b>		23d LOCATION (City or Town) (County) (State) <b>Baltimore, Md.</b>	
24. FUNERAL DIRECTOR <b>Norman Funeral Home Pikesville, Maryland</b>		25a REC'D BY REGISTRAR <b>NOV 14 1967</b>	
25b REGISTRAR'S SIGNATURE <b>Anthony J. Young</b>			



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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

15152

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15155

1 PLACE OF DEATH a COUNTY <u>Baltimore</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE <u>md</u> b COUNTY	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		c LENGTH OF STAY IN 1b <u>2 wks</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Summit Nursing Home</u>		d STREET ADDRESS <u>RT 6</u>	
3 NAME OF DECEASED (Type or print) First <u>Pearle</u> Middle <u>C</u> Last <u>Wolfe</u>		4 DATE OF DEATH Month <u>11</u> Day <u>9</u> Year <u>1967</u>	
5 SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-4-88</u>
9 AGE (In years or birthday) yrs <u>78</u>		10 IF UNDER 1 YEAR Months <u>11</u> Days <u>9</u> Hours <u>19</u> Min <u>67</u>	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>at home</u>		10b KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (County & State or foreign country) <u>Easton, Md</u>		12 CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Edward Casson</u>		14. MOTHER'S MAIDEN NAME <u>Genevieve Russell</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Smallwood Wolfe</u>		Address <u>131 North bend Rd</u>	
18 CAUSE OF DEATH (Enter on only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY <u>260X</u> IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DOE TO <u>poth fibrillation</u> (b) <u>Pericardial disease</u> DOE TO <u>chronic brain syndrome - advanced</u> (c) <u>diabetic mellitus</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>9/23/1962</u> to <u>11/9/1967</u> that (I) (we) last saw the deceased alive on <u>11/8/1967</u> , and that death occurred at <u>12:30 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>E. K. Saitis</u>		22b. DATE SIGNED <u>11/9/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>E. K. Saitis, M.D.</u>		22d. ADDRESS <u>1801 Franklin Rd # 21228</u>	
23a BURIAL, CREMATON, REMOVAL (Specify) <u>Burial</u>	23b DATE THEREOF <u>11-13-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Lorraine Cemetery</u>	23d LOCATION (City or Town) (County) (State) <u>Baltimore, Maryland</u>
24 FUNERAL DIRECTOR <u>Ellsworth Armacost-4600 Liberty Hghts. Avenue</u>		25a REC'D BY REGISTRAR <u>NOV 14 1967</u>	25b REGISTRAR'S SIGNATURE <u>[Signature]</u>





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VR A15 (4)  
25M 1/67

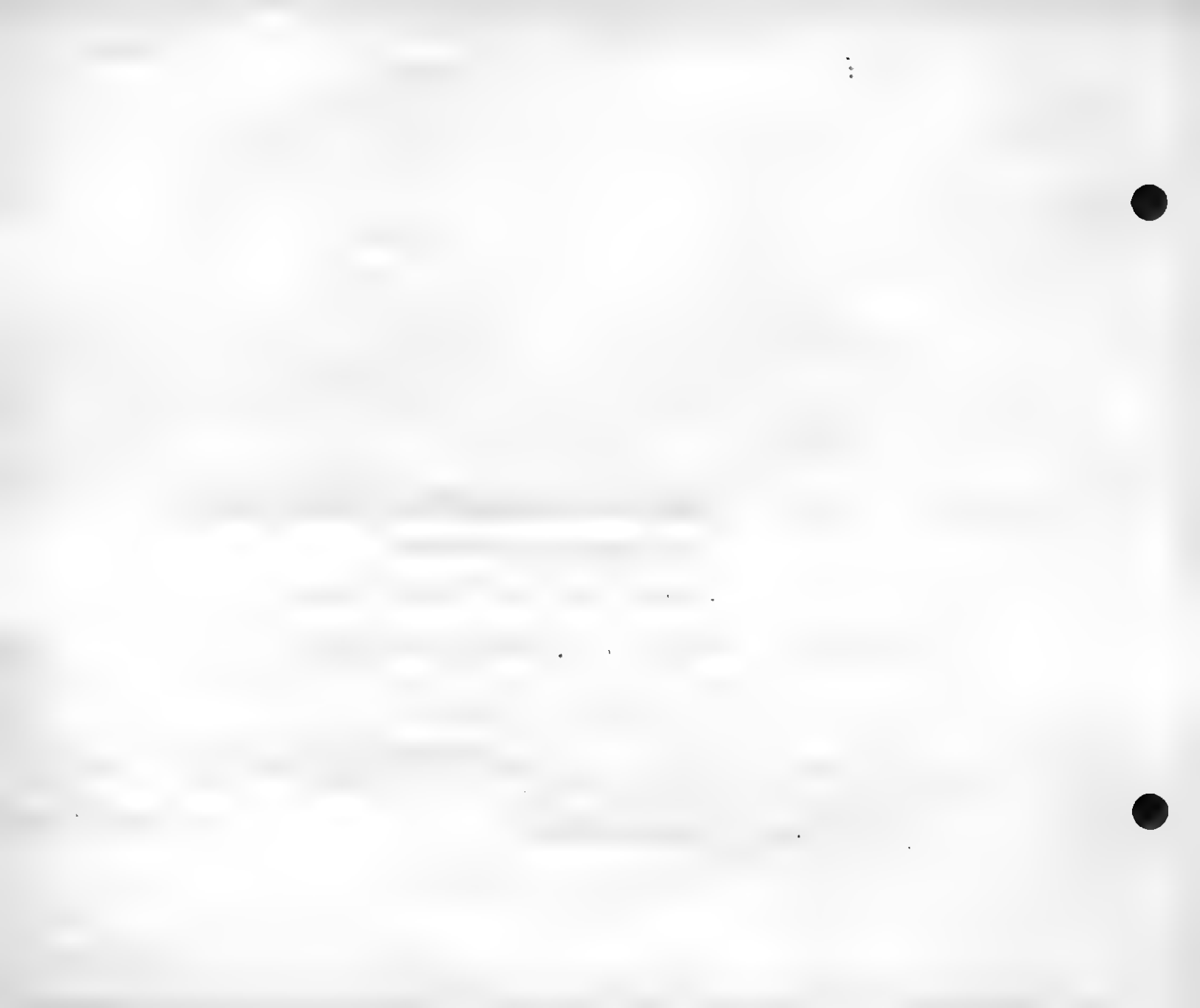
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15153

15156

1 PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u> <u>2944 GRENDALE AVE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TOWSON</u>		c. LENGTH OF STAY IN 1b <u>BALTIMORE</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>CBMC</u>		d. STREET ADDRESS <u>2944 GRENDALE AVE</u>	
3 NAME OF DECEASED (Type or print) <u>Stanley Beckwith Woodruff</u>		4 DATE OF DEATH Month <u>November</u> Day <u>1</u> Year <u>1967</u>	
5. SEX <u>M</u>	6 COLOR OR RACE <u>W</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>4-26-96</u>
9 AGE (In years last birthday) <u>71</u> yrs		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>  </u>	
11. BIRTHPLACE (County & State, or foreign country) <u>LOGANSPORT, INDIANA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13 FATHER'S NAME <u>Lawrence Woodruff</u>		14 MOTHER'S MAIDEN NAME <u>Emma Warbington</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16 SOCIAL SECURITY NO <u>716-01-9232</u>	
17. INFORMANT <u>PT'S CHART</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Congestive Heart failure</u> DUE TO <u>Pulmonary edema.</u> (b) <u>Lower nephron nephrosis</u> DUE TO <u>  </u> (c) <u>  </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>DIABETES MELLITUS, EMPHYSEMA</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (a) (this hospital) attended the deceased from <u>OCTOBER 17, 1967</u> to <u>NOVEM. 1, 1967</u> that (b) (we) last saw the deceased alive on <u>NOV. 1, 1967</u> and that death occurred at <u>5:00AM</u> , from causes and on the date stated above			
22a. SIGNATURE <u>Reiffer Mitchell</u>		22b. DATE SIGNED <u>NOV. 1, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>K. Mitchell</u>		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>11-4-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Garden of Faith</u>	23d. LOCATION (City or Town) (County) (State) <u>BALTO MD</u>
24. FUNERAL DIRECTOR <u>CHAR. F. EVANS JR</u>		25a. REC'D BY REGISTRAR <u>NOV 3 1967</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15154

CERTIFICATE OF DEATH

15157

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) b. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN lb <b>26 dys</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>SPRING GROVE STATE HOSPITAL</b>		d. STREET ADDRESS <b>1113 West Mulberry Street</b>	
3. NAME OF DECEASED (Type or print) First <b>Samuel</b> Middle <b>Clifton</b> Last <b>Wynn</b>		4. DATE OF DEATH Month <b>November</b> Day <b>2</b> Year <b>1967</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 6, 1898</b>
9. AGE (In years last birthday) <b>68 yrs</b>		10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>presser</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
13. FATHER'S NAME <b>?</b>		14. MOTHER'S MAIDEN NAME <b>?</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO <b>119-05-6871</b>	
17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). With chronic congestive Ht. Fail. INTERVAL BETWEEN ONSET AND DEATH PART I. DEATH CAUSED BY: <b>Arteriosclerotic Cardiovascular Ht. Dis. - 1 mon.</b>			
IMMEDIATE CAUSE (a) <b>4 and 1</b> DUE TO (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) <b>Syndrome secondary to Ia. above Cachexia, secondary to anorexia, secondary to chronic Brain</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour <b>0</b> m. <b>19</b> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <b>this hospital</b> attended the deceased from <b>Sept. 29, 1967</b> to <b>Nov. 2, 1967</b> , that <b>we</b> last saw the deceased alive on <b>Nov. 2, 1967</b> , and that death occurred at <b>1125 P.M.</b> causes and on the date stated above.			
22a. SIGNATURE <b>Anthony J. Young, M.D.</b>		22b. DATE SIGNED <b>11/3/67 10:00 A.M.</b>	
22c. PHYSICIAN'S NAME (Type) <b>Anthony J. Young, M.D.</b>		22d. ADDRESS <b>SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228</b>	
23a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11/7/67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Calvary Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>A A County Md</b>	
24. FUNERAL DIRECTOR <b>Adolphus Halstead 1206 W North Ave</b>		25a. REC'D BY REGISTRAR <b>NOV 6 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>O'Connell, Judge</b>			



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

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1 PLACE OF DEATH a. COUNTY <b>Balto.</b> MARYLAND			2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Balto.</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Owings Mills</b>		c. LENGTH OF STAY IN 1b <b>46 yrs.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Owings Mills</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Park Heights Ave.</b>			d. STREET ADDRESS <b>Park Heights Ave.</b>		
3 NAME OF DECEASED (Type or print) <b>Simeon THOMAS Yaruta</b>			4 DATE OF DEATH Month <b>Nov.</b> Day <b>16</b> Year <b>19 67</b>		
5 SEX <b>Male</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>July 17, 1888</b>		9 AGE (In years last birthday) <b>79</b> yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Gardener</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>INDUSTRY</b>		11 BIRTHPLACE (State or foreign country) <b>Russia</b>	
13 FATHER'S NAME <b>?</b>			14 MOTHER'S MARRIAGE NAME <b>?</b>		
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16 SOCIAL SECURITY NO <b>215-30-2685</b>		7 INFORMANT Address <b>Simeon J. Yaruta, Pk. Hts. Ave., Owings Mills, Md</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Arteriosclerotic C-V Disease</b> <b>42 + 1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } DUE TO (b) lost } DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH <b>1 yr</b>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>none</b>					19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> <b>none</b>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>none</b> p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
		20f. (City or town)		(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>D. D. Caples</b>		M.D.		22. DATE SIGNED <b>11-17-67</b>	
EXAMINER'S NAME (Type) <b>D. D. Caples, M. D.</b>		<b>6 Hanover Rd. Beltsville, Md.</b>		23a. REGISTRATION NO. <b>11-17-67</b>	
23a. BURIAL, CREMATION, REMOVAL, (Specify)		23b. DATE THEREOF <b>November 20, 1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Beltsville Cemetery, Beltsville, Md.</b>	
24. FUNERAL DIRECTOR <b>Frank A. Newell, Beltsville, Md.</b>		ADDRESS		25a. REC'D BY REG. STRAR <b>NOV 21 1967</b>	
				25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



## CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH o. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN lb <b>03</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>522 Ingleside Avenue</b>		d. STREET ADDRESS <b>522 Ingleside Avenue</b>	
3. NAME OF DECEASED (Type or print) <b>Walter Livingston Zenker Sr.</b>		4. DATE OF DEATH <b>Nov. 17, 1967</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 11, 1889</b>
9. AGE (In years last birthday) <b>78 yrs.</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Auto. Service Salesman</b>	
10b. KIND OF BUSINESS OR INDUSTRY <b>Sales Agency</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Kent Co., Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		13. FATHER'S NAME <b>Joseph F. Zenker</b>	
14. MOTHER'S MAIDEN NAME <b>Willie Mae Payne</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>	
16. SOCIAL SECURITY NO. <b>212-12-5121-A</b>		17. INFORMANT <b>Catonsville, Md. 21228</b> <b>Mrs. Sophia B. Zenker 522 Ingleside Avenue</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> DUE TO <b>Art. Sel. Heart Dis.</b> DUE TO <b>Cong. Heart Failure</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Hypertension Essential; Inguinal Hernia</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 min</b> <b>5 yrs.</b>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <b>June 22, 1962</b> to <b>Nov 12, 1967</b> that (I) (we) last saw the deceased alive on <b>Nov 2, 1967</b> , and that death occurred at <b>8:05 PM</b> , from causes and on the date stated above.	
22a. SIGNATURE <b>John N. Snyder</b>		22b. DATE SIGNED <b>11/20/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>John N. Snyder M.D.</b>		22d. ADDRESS <b>6348 Frederick Rd. Baltimore, Md. 21228</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Entombment</b>		23b. DATE THEREOF <b>Nov. 20, 1967</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Lorraine Mausoleum</b>		23d. LOCATION (City or Town) (County) (State) <b>Woodlawn Balto. Co., Md.</b>	
24. FUNERAL DIRECTOR <b>Easton Funeral Home</b>		25a. REC'D BY REGISTRAR <b>Charles Judge</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		DATE <b>NOV 20 1967</b>	

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# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dundalk</b>		c. LENGTH OF STAY IN TB <b>10 Years</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>7907 Diehlwood Road</b>		d. STREET ADDRESS <b>7907 Diehlwood Road</b>	
3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>Ann</b> Last <b>Zuber</b>		4. DATE OF DEATH Month <b>November</b> Day <b>20</b> Year <b>1967</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 28, 1903</b>
9. AGE (In years last birthday) <b>63 yrs.</b>		10. IF UNDER 1 YEAR Months <b>03</b> Days <b>1</b> Hours <b>00</b> Min. <b>00</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Seamstress</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Chester Shirt Mfg. Co. Pennsylvania</b>	
11. BIRTHPLACE (State or foreign country) <b>U. S. A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>John Kanarowsky</b>		14. MOTHER'S MAIDEN NAME <b>Ann Mecavage</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>165-18-2982</b>	
17. INFORMANT (Husband) <b>Mr. Alex Zuber, 7907 Diehlwood Rd. Dundalk,</b>		Address <b>Md. 21222</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Coronary Occlusion</b> DUE TO <b>HCUV</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost: (b) _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH <b>approx 2-3 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. _____ p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Theodore C. Patterson</b> M.D.		22. DATE SIGNED <b>11/20/67</b>	
EXAMINER'S NAME (Type) <b>Theodore C. Patterson</b> M.D.		23. CHIEF MEDICAL EXAMINER <input type="checkbox"/> 105 Main Street ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> Dundalk, DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Md. 21222 Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>11/23/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Blessed Virgin Mary Cem.</b>	23d. LOCATION (City or Town) (County) (State) <b>Mahanoy Township, Schuylkill Pa.</b>
24. FUNERAL DIRECTOR <b>John J. Duda, 7922 Wise Ave. Dundalk, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>NOV 24 1967</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b> Co.

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